

No. 22-99006

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT**

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Clarence Wayne Dixon,  
Petitioner-Appellant,

vs.

David Shinn, et al.,  
Respondents-Appellees.

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On Appeal from the United States District Court  
for the District of Arizona  
Case No. 2:14-cv-00258-DJH

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**Excerpts of Record  
Volume 4 of 4**

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JON M. SANDS  
Federal Public Defender  
District of Arizona

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*Clarence Wayne Dixon*



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**LICENSURES & CERTIFICATION**

**Licensures** Arizona #17900,  
 DEA # BA1622061, XA1622061(Buprenorphine License)

**Certification** Fellow, American Psychiatric Association  
 Diplomate, American Board of Psychiatry & Neurology,  
 Diplomate, Diplomate America Board of Adolescent Psychiatry,  
 Diplomate, American Board of Forensic Medicine

**Languages:** English and Spanish

**PROFESSIONAL EXPERIENCE**

**(Current Positions)**

<b>Medical Director-CEO -President</b>	<b>Metropolitan NeuroBehavioral Institute, PLLC</b>	<b>2005 - Current</b>
<b>President</b>	<b>Metropolitan Consulting Corporation</b>	<b>2008 - Current</b>
<b>Medical Director</b>	<b>Oasis Behavioral Health Hospital</b>	<b>2013 - Current</b>
<b>Medical Director</b>	<b>Footprints to Recover Detox Residential</b>	<b>2017 - 02/2019</b>

**(Past Positions)**

Adolescent Medical Director	Aurora Behavioral Healthcare Tempe Hospital	2012 - 2013
Medical Director	Youth Development Institute (sex offender RTC) Metropolitan	1999 - 2007
Medical Director - CEO Chairman	Psychiatric Physicians, PC	1994 - 2005
Adolescent Services Director Medical	Aurora Behavioral Health Hospital	2010 - 2012
Director Crisis Services Director of Crisis	Banner Desert Medical Center	2001 -2006
Assessment Medical Director	MBC/Biodyne Arizona	2000 - 2005
Director of Assessment	St. Luke's Behavioral Health Center Arizona	1993 - 2001
Medical Director Crisis/UM Director C.	Partnership for Youth and Families	1996 - 2001
Dependency Services Director	Desert Vista Hospital	2001 - 2003
C. Dependency Services Associate Med.Dir	Charter Behavioral Health System Charter Medical - East	1995 - 1999
Medical Director	Valley Desert Vista Hospital	1996 -1996
Medical Director	ComCare	1991 - 1995
Medical Director	Maricopa Clinical Management	1992 -1994
Medical Director	East Valley Behavioral Health Assoc.	1992 - 1993
Emergency Psychiatry Director Hispanic	Maricopa Medical Center-Director ER Psych	1990 - 1992
Consultant	Arizona State Hospital	1989 - 1991
Staff Psychiatrist	Camelback Community Counseling East	1988 - 1990
Consulting Psychiatrist Emergency Psych.	Valley Alcoholism Council	1988 - 1990
Consultant	Human Dynamics Institute	1988 - 1990

**Lauro Amezcua-Patiño, MD, FAPA****CV****EDUCATION**

Psychiatry Residency  
 Family Medicine Externship  
 Clinical Internship  
 Medical Degree  
 College Degree

**INSTITUTION**

Maricopa Medical Center  
 University of California, Irvine. Dept. Family Medicine  
 Instituto Mexicano del Seguro Social, Mexico  
 Escuela de Medicina de Mexicali, UABC, Mexico  
 Instituto Salvatierra, UABC, México

**GRADUATION**

1989  
 1984  
 1982  
 1981  
 1977

**HOSPITAL STAFF PRIVILEGES**

Oasis Behavioral Health Hospital

Prior Privileges at St. Joseph's Hospital/Barrows Neurological Institute, St. Luke's Hospital and Medical Center, Banner Desert Medical Center, Desert Vista Hospital, Maricopa Medical Center, Mesa General Hospital, Chandler Regional Hospital. Tempe St. Luke's, Aurora Behavioral Healthcare Tempe, Scottsdale Health Care Systems, Honor Health.

**PROFESSIONAL ASSOCIATIONS:**

American Psychiatric Association  
 Fellow. 2003 to Date

Arizona Psychiatric Society -  
 Past President 1997 - 1998  
 President 1995 - 1997  
 President Elect - 1994  
 Vice President - 1993  
 Secretary - 1992  
 Treasurer - 1990 - 1991  
 Government Relations Committee - Co-chair- 1990 -  
 2001 Ad Hoc Committee, Legislative Issues - Chair 1990  
 American Neuropsychiatric Association American

**GOVERNOR'S APPOINTMENTS:**

*Member, Joint Legislative Committee on Sex Offender Treatment-Summer-Fall 1997 Governor's Behavioral Health Action Committee, Member 1993-94*  
*State of Arizona, Psychiatric Security Review Board, Member 1997 to February 2006*  
*Vice-Chairman, June 1999 to 2001*  
*Chairman, April 2001 to February 2006*  
*Member, Arizona State Hospital Capital Construction Committee Jan 2000 to Dec 2002*

**ACADEMICS:**

*Adjunct Assistant Professor of Medicine-Midwestern University, Phoenix, Arizona. 7/1998 to Date*  
*Adjunct Assistant Professor of Medicine-AT Still University, Arizona. 02/2014 to Date*

**FOUNDATIONS AND NOT FOR PROFIT ORGANIZATIONS:**

*Board Member, Ballet Arizona, 1990-1993*

**CORPORATE DISCLOSURES:**

*Prior Member of Speaker's Bureau for: Astra-Zeneca, Lundbeck/Takeda Pharmaceuticals, Lilly Pharmaceuticals, Pfizer, Merck.*  
*Current Member Speaker Bureau for Otsuka Pharmaceuticals*  
*Prior Member Cultural Diversity Board and Zyprexa Board, Lilly Pharmaceuticals. Member, Advisory Board, Republic Bank, AZ.*  
*Member, Governing Board, Oasis Behavioral Health Hospital Dec 2013 to Date.*



**PUBLICATIONS:**

*Removing the Mask. Mental Health and the Hispanic Patient"*

Cover Story April 2006 [http://www.mdnetguide.com/departments/2006-april/mc\\_cover.htm](http://www.mdnetguide.com/departments/2006-april/mc_cover.htm)

"What you should know and are afraid to ask, Drugs among children and adolescents" a parent's guide. Publish America, 2004. ISBN

1-4137-2647-X. [www.publishamerica.com](http://www.publishamerica.com)

**Most recent Research Experience/Principal Investigator:**

*2008 Pfizer protocol A1281158, 2008*

*Otsuka Aspire 246 Protocol,*

*2009 Covance 31-07-246 Protocol.*

*2018 Molindone Double Blind Protocol, Aggression Associated with ADHD*

*2017 Ketamine Infusion for the treatment of Post Partum depression*

*2019 OCD Double Blind New compound Study*

**Forensic Medical Experience**

*Extensive forensic medico-legal experience in both Criminal and Civil Cases, particular expertise in Death Penalty Cases involving mental health issues, including high profile cases, locally and nationally. (list of cases upon request)*



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**Lauro Amezcua Patino, MD, FAPA<sup>1</sup>**

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Patient Name: Dixon, Clarence  
Age: 66 years old  
DOB: 08/26/1955  
Sex: Male  
Ethnicity: Native American  
Date of Evaluation: August 25, 2021, February 17, 2022, March 10, 2022, April 19, 2022  
Court Case Number: CR2002-019595  
Referral Source: Office of the Federal Public Defender, District of Arizona  
Psychiatrist: Lauro Amezcua-Patino, MD, FAPA.

**Addendum to 03/31/2022 Report<sup>2</sup>**

At the request of the Federal Public Defender, District of Arizona, Mr. Clarence Dixon was re-evaluated on April 19, 2022. He was informed of the request for evaluation and the limits of confidentiality, and he verbally consented to the re-assessment.

Clarence was evaluated in Browning Unit at the Arizona State Prison Complex in Florence, Arizona in a private room, with a guard observing outside of the door. Since our last visit on March 10, 2022, Clarence has been moved to a different unit and placed under a Death Watch protocol.

**Interview summary April 19, 2022**

The writer discussed with Clarence the most recent legal filings and his understanding of the process. When discussing legal issues, he became quite concrete and repeated frequently that his pleadings are being denied without any explanation, "Because they don't have a legal rationale." "They just want to kill me." He stated, "The courts are the bread and butter, attorneys lie, the attorneys are in agreement with law enforcement." "The system is against me because I am attacking law enforcement." "The judicial system was started to keep black men under control."

Clarence was able to describe the components of the judicial system as previously described, however, he has significant difficulty assisting his attorneys because he is not able to understand the irrationality of his legal arguments and he continues to focus on deluded and conspiratorial beliefs about why his legal arguments have been consistently and repeatedly denied. He reported that his understanding of the law is black and white, and he cannot see it any other way. He reported

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<sup>1</sup> My CV is attached hereto as Exhibit A.

<sup>2</sup> My March 31, 2022 report is attached hereto as Exhibit B.

that his attorneys are filing documents with the clemency board, but he believes he must be released because of the unconstitutional basis of his arrest.

Since the last visit, Clarence has heard a voice calling his name and again reported that he has heard this voice since 1977, “when we moved to Tempe.” Clarence admitted to having unusual experiences when alone in his cell, such as feeling somebody touching him. He reported that he has spent a lot of alone time in his life and described himself as a loner: “I have never had friends but I like helping people.”

Clarence reported having had multiple Sweat Lodge Ceremonies while in prison and, at times while in sweat lodge, he would feel himself spinning and floating outside of his body, but always aware that he was on his knees on the floor. “I felt like everything was part of me.”

He reported that over the years he has dealt with stress by “laying on my boat, then a thought will come to my mind like, should I have a cup of coffee; I say no, and then I hear a voice telling me ‘but is a warm cup of coffee.’ I have an eternal of experiencing me from me”; “I live inside of my little universe, because the universe outside wants to kill me.”

Clarence was noted to have lost weight since the last visit in March 2022 and was noted to be constantly coughing. He reported that his “Valley Fever” medication was discontinued when he was transferred to Death Watch.

Clarence was noted to be withdrawn, tired, and somewhat fatigued. He reported that his sleep is erratic but denied any active suicidal or homicidal ideas.

Clarence’s affect was flat, mood depressed, associations were noted to be at times circumstantial and at times concrete. Paranoia was noted in his descriptions of the prison staff with whom he comes into contact on Death Watch, his exaggerated distrust of the judicial system, and his unwillingness to let people engage with him emotionally.

Clarence’s depression appears to be significantly worse and he is experiencing further decompensation of his mental faculties. He has stopped taking showers. As he nears execution, his tendency is to retreat into the delusional world that he has created for himself which makes it more difficult to communicate with him in a fact-based way. Throughout my questioning of him, Clarence was disconnected from the reality of his surroundings and situation. He also exhibits a grandiosity consistent with the schizophrenia diagnosis that results in him seeing himself above the legal system that he believes is trying to illegally kill him.

#### **Referral questions:**

1. Is Clarence’s mental state so distorted, or his concept of reality so impaired, that he lacks a rational understanding of the State’s rationale for his execution?
2. Does Clarence’s mental illness prevent him from rationally understanding the relationship between his crime and the punishment, or from grasping the societal values the State seeks to vindicate through his execution resulting from the severity of his crime?

In my best opinion, Clarence suffers from a psychiatrically determinable impairment that significantly affects his ability to develop a rational understanding of the State's reasons for his execution.

Clarence is disconnected from reality, especially as it relates to his legal case. His visual, auditory, and tactile hallucinations further aggravate his detachment from reality. Clarence's thought process is contaminated by concrete thinking, which is common in those diagnosed with schizophrenia. Clarence's concrete thinking causes him to fixate on an issue that limits his ability to abstractly consider the societal values the State seeks to vindicate through his execution. This results in his inability to form a rational understanding of the State's reasons for his execution.

Clarence holds a fixed delusional belief that his incarceration, conviction, and forthcoming execution stem from his wrongful arrest by the NAU police in 1985. That belief has no basis in fact—since it was the Flagstaff Police, *not* the NAU police, that arrested him (FPD 7027-7029)—nor is Clarence able to grasp that this belief has no basis in fact, which renders Clarence's understanding of why he'll be executed irrational.

For decades, Clarence has fixated over and pursued these delusional beliefs to his detriment: He fired his court-appointed attorneys and represented himself at his capital trial after they refused to raise this factually baseless issue; and he has filed appeals over this issue nearly thirty times in numerous state and federal courts.

Despite explanations from prior lawyers and the courts for why the issue is baseless, Clarence is unable to rationally understand why he has not obtained relief on this issue. Clarence also holds a fixed delusional belief that the repeated denial of his pro se pleadings related to the NAU issue are the result of a judicial conspiracy. This is reflected most recently in letters Clarence has written to Arizona Republic Reporter Laurie Roberts and to the Arizona Commission on Judicial Ethics (FPD 7898-7899, FPD 8211-8212). In his letters, Clarence claims, "My story involves the deliberate mishandling of a case, mine, so that an execution could result" (FPD 7898); and he demands that the Arizona Supreme Court Justices be disbarred, stating that "their lack of impartiality and fairness leads directly to an extra-judicial killing, an illegal and immoral homicide created in the name of and for the good people of Arizona." (FPD 8211-12).

Clarence's pro se filings over many decades reveal his delusional, paranoid, and conspiratorial thought content. He has, for instance, expressed the irrational beliefs that: his prior lawyers "purposefully exclude[ed] the [NAU] issue" (FPD 6547); courts have "refused and ignored applying relevant law" because of the nature of his crime and possibility of his release (FPD 6562); relief has been denied on this claim because "[t]he State is embarrassed that for many years [the NAU police] has operated without statutory authority[]" (FPD 6563); the courts' action on the NAU issue reflects their deliberate and "continued evasion" of his right to relief (FPD 6780); the courts have engaged in "obvious subterfuge" (FPD 6790, FPD 6952) and are purposefully in "collusion" to deny him his rights (FPD 6973-6980); that the "cumulative, continuous and concerted effort by state and federal judges on its face smacks of collusion and conspiracy or, at the least, complicity and the reader is left considering the circumstantial weight to tell if judicial collusion is found[]" (FPD 6980; *see also* FPD 6983); and that judges have engaged in deliberate

“obstruction” in denying his NAU claim (FPD 6988) evidencing their “spirit of ill-will towards [him]” (FPD 7356-7357). Clarence also believes that the courts have denied his claim “because to follow and apply the law would have been politically disastrous, a dark embarrassment to the state universities.” (FPD 6962.)

Clarence’s delusions are not solely focused on the factual basis of his claim, but he expresses deluded and paranoid beliefs about why the issue has been repeatedly denied by the courts. His historical writings demonstrate a longstanding delusional belief that the courts, the prosecution, and his own counsel have conspired to wrongly deny his NAU claims so that he can be illegally executed. This delusional belief is consistent with Clarence’s diagnosis of schizophrenia with paranoid ideations. Clarence’s recent writings show a significant escalation of these delusions, including his belief that the Arizona Supreme Court justices “ghoulishly inflict a constitutional[ly] infirm, illegal and immoral homicide upon my person and body.” (FPD 7877, FPD 7881, FPD 7886, FPD 7891.) Clarence believes the Arizona Supreme Court justices will be disbarred and has reported each justice individually to the Commission on Judicial Conduct. (FPD 7873-7897.) Clarence believes that the prosecutors and judiciary have conspired to “ignore statutes and uphold unlawful and unconstitutional convictions.” (FPD 6028-6029.) Clarence believes the Arizona Supreme Court, United States Supreme Court, and almost all other levels of the courts have conspired to deny his NAU claim so they can execute him, including to protect the State of Arizona and its universities from political embarrassment. (FPD 6562-6563, FPD 6962, FPD 6965). As discussed below, these paranoid delusions significantly impair Clarence’s ability to rationally contemplate his crime, punishment, and the relationship between the two.

While Clarence can verbalize a surface awareness that the State intends to execute him for a crime that occurred in 1978 and for which he was convicted, it is my professional opinion that Clarence nonetheless lacks a rational understanding of the State’s reasons for his execution. That is because, at bottom, Clarence ultimately believes that he will be executed because the NAU police wrongfully arrested him in 1985 and the judicial system—and actors in it, including his own lawyers—have conspired to cover up that fact. Clarence cannot rationally draw a connection between his crime and punishment because he is unable to contemplate the societal values the State seeks to uphold through his execution. When Clarence is prompted to think about his execution, his contaminated thought process prevents him from focusing on anything other than his delusional obsession that there exists a vast conspiracy to deny him relief on an issue that is completely unrelated to the crime for which he was sentenced to death. As a result, Clarence does not rationally understand the relationship between his crime and his impending execution. Clarence cannot rationally understand that the State seeks, through his execution, vindication due to the severity of his offense. Instead, he believes the State’s rationale for his execution involves a conspiracy to wrongly deny his NAU claim in order to illegally murder him for political reasons.

Clarence’s hallucinations also appear to relate to his conspiratorial delusions. His belief that the goal of the judicial system is to “keep black men under control” may relate to his persistent hallucinations of a white child watching and laughing at him. Clarence reports that he is upset that the child is white.”

As the records, Clarence’s history, and my evaluations illustrate, while Clarence can verbalize an awareness of the legal process and has a limited capacity to exercise rational judgment in some

areas of life, his beliefs about why he is incarcerated and why the State seeks to execute him are fundamentally irrational. His capacity to understand the rationality of his execution is contaminated by the schizophrenic process which results in his deluded thinking about the law, the judicial system, his own lawyers, and his ultimate execution despite multiple attempts over many years to disabuse him of his irrational beliefs.

3. How has Death Watch affected Clarence Dixon's mental state?
4. At the time of Clarence's reevaluation, he had been on Death Watch for 14 days. The effects on Mr. Dixon are apparent. Since the last evaluation, Mr. Dixon has mentally decompensated. He is more withdrawn and presents with severe depression. He has stopped showering and his paranoia has increased.

It is a well-known fact that the extreme isolation of any individual leads to severe psychological and psychiatric distress; vulnerable individuals such as those with mental disorders are particularly more susceptible to decompensations.

In Clarence's case, the psychosocial and physical stress related to increased isolation, lack of any privacy, and 24-hour supervision has likely worsened his delusional and paranoid thinking, initiated a new depressive episode, and worsened his anxiety. In the context of his blindness, deathwatch becomes is a new challenge with new uncertainties that challenges all of his acquired abilities to manage his blindness.



Lauro Amezcua-Patino, MD, FAPA.

April 25, 2022

Date

Lauro  
Amezcua  
Patino  
MD

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by Lauro  
Amezcua Patino  
MD  
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Patient Name: Dixon, Clarence  
Age: 66 years old  
DOB: 08/26/1955  
Sex: Male  
Ethnicity: Native American  
Date of Evaluation: August 25, 2021, February 17, 2022, March 10, 2022  
Court Case Number: CR2002-019595  
Referral Source: Office of the Federal Public Defender, District of Arizona  
Psychiatrist: Lauro Amezcua-Patino, MD, FAPA.

**Psychiatric Evaluation**

The patient was referred for psychiatric re-evaluation by the Federal Public Defender, District of Arizona. Mr. Clarence Dixon was informed of his attorney's request for evaluation and the limits of confidentiality, and he provided verbal informed consent for the review. Clarence was previously evaluated by this writer in 2012 at the age of 55 for a psychiatric diagnostic assessment at the Browning Unit of the Arizona State Prison Complex in Florence, Arizona.

**Referral Questions:**

1. Is Clarence Dixon's mental state so distorted, or his concept of reality so impaired, that he lacks a rational understanding of the State's rationale for his execution?
2. Would Death Watch increase the likelihood that Clarence Dixon would manifest or experience a worsening of any impaired mental states described in Question 1? If so, why?

**Method:**

Clarence was evaluated by this writer in Central Unit at the Arizona Department of Corrections facility in Florence, Arizona for approximately 2 hours for a Clinical Interview and verification of history on Wednesday, August 25, 2021; again for approximately 1 hour on Thursday February 17, 2022, at the same facility; and for a third time for approximately 1 hour on Thursday, March 10, 2022, at the same location.

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<sup>1</sup> My CV is attached hereto as Exhibit A.

### **Records provided for review:**

The records provided for my review are attached hereto as Exhibit B.

### **History:**

Mr. Clarence Dixon is a 66-year-old Native American currently residing in the Central Unit of the Arizona State Prison Complex in Florence, Arizona. Since my prior report approximately 11 years ago, Clarence has developed significant visual deterioration, to the point of being declared legally blind in 2015. (FPD 5069.)

He was cooperative and eager to participate in a conversation with this writer. He reported that he has been experiencing significant difficulty sleeping, primarily problems with sleeping irregularly and at different times of the day. He admits to feeling occasionally fatigued.

### **Past Psychiatric History:**

Mr. Dixon has a long history of mental disturbances affecting his life. He remembers suffering from severe depression at age ten and manifested by feelings of hopelessness, helplessness, decreased energy, decreased motivation, and a lack of interest. He states he suffered from three such episodes prior to his incarceration.

On June 5, 1977, Clarence was arrested by the Tempe Police Department for assaulting Christy Guerra, age 15, with a metal pipe, causing a severe cut to the top of her head. Ms. Guerra stated that Clarence walked up to her stating "Nice evening, isn't it?" before striking her. Ms. Guerra screamed and Clarence retreated to his vehicle followed by Ms. Guerra. Tempe Police arrived on the scene and took Clarence into custody. He was charged with Aggravated Assault with a Deadly Weapon.

Dr. Maier Tuchler and Dr. Otto Bendheim were retained by the Maricopa County Superior Court to determine if Clarence was competent to stand trial.

On September 2, 1977, Dr. Tuchler found Clarence incompetent to stand trial and further opined that Clarence exhibited "several characteristics which are clearly abnormal. Although he is oriented for time, place, and person, and is fairly well educated, he is exceedingly slow in responses, markedly withdrawn, and obviously depressed. Blocking is characteristic and has prolonged the interview interminably." Dr. Tuchler stated his belief that Clarence may have been lashing out at the victim, Christy Guerra while responding to fantasies that he was attacking his wife. He further stated, **"It is the opinion of this examiner that at the commission of the offense Clarence Dixon was presenting a transient mental illness in which reality was lost to him, and he presented as an undifferentiated schizophrenia (sic)."**

On September 2, 1977, Dr. Otto Bendheim found the defendant incompetent to stand trial, stating "he is so severely depressed he blocks so much and hesitates between answers to the

extent that many answers remain totally unanswered." He further stated, "I believe this man is suffering from very severe depression, possibly with an underlying psychosis. The exact nature of his mental illness could not be determined, but schizophrenic psychosis is considered to be the most likely diagnosis. " Dr. Bendheim opined, **"without the presence of the mental disturbance, the act of violence would not have taken place."**

On September 15, 1977, Clarence was placed at the Arizona State Hospital to restore competency. On October 6, 1977, David L. White, Ed.D stated that he believed Clarence's poor emotional condition to be the result of a poor marital situation which he has perceived as being without a solution. He was seen as being racked by guilt and depression, and, although Clarence believed he would not harm himself, he could manage to "accidentally" die or be killed by someone else.

Clarence (has reported) further hat on one occasion, his father beat him severely and, for this and other reasons, he harbored animosity towards his father. On October 26, 1977, Clarence was believed to be competent to stand trial by John W. Marchildon, MD. Dr. Marchildon stated that Clarence did not have a mental illness at the time of his evaluation, diagnosing him with Social Maladjustment without Manifest Psychiatric Disorder and Marital Maladjustment.

On December 12, 1977, the Honorable Sandra Day O'Connor requested an opinion of the doctors as to whether the defendant was in "such a state of mind that he did not know right from wrong and whether the defendant knew the quality and nature of his acts and consequences thereof at the time of the commission of the alleged offense." On January 5, 1978, Clarence was found not guilty by reason of insanity. The Court ordered the County Attorney's Office to commence civil commitment proceedings, but Clarence remained out of custody. Two days later, Deana Bowdoin was found in her apartment, sexually assaulted and murdered.

Clarence has consistently reported experiencing auditory and visual hallucinations on many occasions. He is somewhat guarded and defensive when asked about these perceptions, and it is obvious he doesn't like talking about them.

This writer conducted a psychiatric evaluation of Clarence on September 7, 2012, for approximately two hours at the Browning Unit of the Arizona State Prison Complex in Florence, Arizona. I noted that Clarence was guarded and defensive in his demeanor, especially when discussing his psychiatric history. I diagnosed him with schizophrenia, paranoid type, chronic and major depression, recurrent.

John Toma Ph.D. evaluated Clarence in excess of fourteen hours over the following dates: 04/18/2012, 04/19/2012, 05/02/2012, and 06/26/2012. This evaluation consisted of clinical interviews, as well as a battery of neuropsychological testing to determine if Clarence suffered from any psychological abnormalities. There were several elevated scales on the Minnesota Multiphasic Personality, indicating Clarence is mistrustful of others, and not comfortable in social situations, has unrealistically high expectations about other people while at the same time being fearful of others, believing they may harm him.

Clarence's scores on the Schizophrenia scale indicate he experiences "a number of unusual beliefs, that he may become withdrawn, may rely excessively upon fantasy and that he may be generally sad, blue, anxious and on the Restructured Clinical scale. Clarence showed a significantly elevated response to the Antisocial Behavior scale (RC4). "This scale indicates Clarence has trouble conforming his behavior to the law, and it reflects his years of illicit drug and alcohol abuse."

On the Rorschach Inkblot Test, Clarence consistently gave responses showing paranoid ideation and psychotic content, as well as some morbid responses indicating difficulties with depression. He also made a number of very bizarre comments or made several responses that included symbolism which is almost exclusively given by schizophrenic patients. During this test, Clarence became quite agitated and paranoid, and at the end of the test, he angrily accused Dr. Toma of "getting into my head."

Dr. Toma diagnosed Clarence as suffering from schizophrenia, paranoid type and considered ruling out schizoaffective disorder, depressed type, and cognitive disorder, NOS. He further diagnosed alcohol dependence by history. In his conclusions, Dr. Toma states, "It is clear now, with the test data obtained during this evaluation, that the Rule evaluators for his first conviction in 1968 were accurate in their opinions that he suffered from a psychotic disorder. At the time of the murder of Deana Bowdoin, he would have been in the early stages of a schizophrenic illness."

### **Substance Abuse History**

Clarence stated that he started smoking marijuana at age fourteen. He said he was "never a regular smoker" but would use the drug when available. He stated that he sometimes used this substance with his wife Geraldine Eagleman but was not a hard-core user. He has said that he used methamphetamine a couple of times but never really liked the drug.

Clarence reportedly began using alcohol at around age sixteen on an occasional basis. He stated that his drinking increased to the point that he was drinking probably every night. Clarence reportedly drank daily from 1977 until he went to prison in September of 1978. He said he would usually drink beer but sometimes drink a bottle of vodka. He stated that he experienced frequent blackouts from vodka at this time. He described his blackout frequency from vodka as "about once every two or three weeks."

### **Medical History**

Clarence has experienced various medical issues throughout his lifetime. He was born with a congenital heart defect known as coarctation of the aorta (FPD 001.) Before reaching the age of two, he experienced seizures. (FPD 039-040.) On September 6, 1959, at age four, he was seen for a cut on his forehead due to hitting a door and received stitches. (FPD 006.) On June 29, 1960, Clarence received services from a physician after a mirror fell and shattered, cutting his right leg and necessitating sutures. (FPD 008.)

Medical records show Clarence continued to suffer from cardiovascular problems. In 1961, at around age six, he was noted to lack a palpable pulse in his lower extremities. (FPD 009-010.) In 1967, Dr. M. Molthan noted 12-year-old Clarence had a murmur, a history of leg cramps, and a cardiac catheterization done in the past. (FPD 035.) Dr. Molthan concluded Clarence suffered from coarctation of the aorta and recommended surgery. (FPD 035.) On February 6, 1968, Clarence had open-heart surgery in Phoenix to repair his aorta. (FPD 035-036.) It should be noted that when Clarence was on his way home from the hospital, he was preoccupied with fear at his father's perceived anger at him since he had forgotten his shoes at the hospital. (FPD 122.) About three weeks after undergoing heart surgery, on February 20, 1968, Clarence was hospitalized for three days due to weakness and discomfort at the operative site.

As an adult in his mid-twenties, Clarence was noted as having a history of rheumatic fever, aorta complications, and a heart murmur. (FPD 291.) An electrocardiogram (EKG) report dated January 5, 1979, indicated possible left atrial hypertrophy or intraatrial conduction defect. (FPD 545.) When Clarence was in his early forties, in October 1997, an EKG noted moderate to severe aortic insufficiency with normal left ventricular dimension and systolic function. (FPD 385.)

Clarence was diagnosed with glaucoma in 2000. (FPD 557.) On February 6, 2015, Dr. Michael Horsely deemed Clarence legally certified as blind in both eyes. (FPD 5069.) In June 2020, EKG results indicated sinus bradycardia, possible left atrial enlargement, rightward axis, incomplete right bundle branch block, and abnormal. (FPD 1443.) In July 2021, Clarence started receiving treatment for Coccidioidomycosis, also known as Valley Fever. (FPD 5207.) He has intermittently received a special wasting diet since 2012 (FPD 783, 779, 837, 916, 1045) with an order recently placed in January 2022 due to his underweight body mass index (BMI). (FPD 5800.)

### **Psychosocial History:**

Clarence was born on August 26, 1955, at the Navajo Medical Center in Fort Defiance, Arizona, the third of six children of Wilbur and Ella Dixon and reportedly born as a “blue baby” due to a congenital heart condition known as coarctation of the aorta. He was apparently delivered in breech presentation, weighed less than six pounds, and remained in an incubator his first month of life.

Clarence has described his upbringing as troubled due to his belief that his father was cold and domineering with no praise for the children. He has described his mother as a tranquil and passive person.

As a child, Clarence feared his father who reportedly spoke to Clarence and his siblings in a demeaning manner, frequently telling them they were worthless. His father was belligerent and abusive. If one child did something to anger Clarence's father, he would punish all children. He would reportedly line the children up and hit them with a belt until they cried. It should be noted that Clarence's father suffered from migraine headaches, has been described as having “mental problems,” and was prescribed Darvon and Librium.

Clarence's mother did nothing to stop his father's violent tirades and never asserted herself to protect the children. Clarence has reported feeling betrayed by his mother.

In high school, Clarence recalls being beaten up by his father for a minor transgression. He was sent to California to live with his sister Ellen. According to Clarence's brother Perry Dixon, Clarence was "pretty beat up" when placed on the bus to California.

On March 18, 1975, Clarence married Geraldine Eagleman in Window Rock, Arizona. They moved in May 1976 to Tempe, Arizona, where both planned on attending college. This was, by all accounts, an unhappy marriage. Clarence stated that the girl he assaulted in 1977 bore a "superficial resemblance to his wife." Geraldine divorced Clarence in 1979 while he was in prison.

### **Mental Status Examinations:**

#### **Interview summary August 25, 2021**

Mr. Dixon was brought into a private interview room with assistance from guards due to his blindness, sat straight in front of me, and agreed to have a conversation with this writer. During the interview he stated, "The State is trying to execute me" and "They charged me with first-degree murder in 2002." When confronted with the state of his recent legal issues related to the death sentence, he stated, "There are issues of jurisdiction that can be brought up anytime; it is the black letter of the law." Clarence became excited about the conversation and when confronted with the number of appeals he has submitted on this issue he stated, "They never explain why my claims are denied."

When asked about what it is like to be on death row, he stated, "I have been in prison for 35 years, I hold my biological imperative, I need to further myself, I have a strong biological imperative, I need to further myself."

He further stated, "They believe I am guilty" and conveyed his belief that it was for no other reason that because they "say so." "They are not following their own rules," he said. He denied feeling that being Native American or Navajo explains this.

We discussed Clarence's history of psychiatric illness and he was asked about his recollection of being found Not Guilty by Reason of Insanity. He stated, "I was found incompetent in court in the past, I was ordered to the Arizona State Hospital, and someone dropped the ball."

He reported that when he was young, he was "weak and stupid." He also stated that: "My wife messed up with my head. She wanted a good life and a good provider. We got married quite quickly. When we moved to Tempe, she took an overdose of aspirin. She felt I did not bring anything to the marriage. I brought nothing to the marriage. I was working at the time."

He reported difficulty trusting anybody. When asked about his hopes, he stated: "I want them to recognize the Law. They are not disagreeing with me; they just want to kill me for murder. They are ignoring the law."

Clarence reported that when he feels the guards are nudging him, he tries to go to sleep and follow “Andy.” He believes that Andy is his deep self, and when he wakes up, he says, “I am not going to be weak and slow.”

Clarence admitted to hearing voices speaking to him inside his head. He stated, “There is something inside of me that is loose. I am loco, I am broken.”

He admitted to feeling quite angry about himself. “The anger comes from somewhere.” He also reported during this interview that there are two ghosts inside of his cell and that “somebody touches me in my shoulder, I turn around, and nobody is there.”

### **Interview summary February 17, 2022**

Mr. Dixon was brought into the private interview room by a guard who assisted him to his chair due to his blindness. The interview was initiated by re-introducing myself, obtaining verbal informed consent for the interview, and explaining the purpose of the visit.

He was asked initially if he was aware that the State of Arizona may have filed for a date of execution in his case. He reported being aware. When asked about his feeling about this filing, he stated:

Sometimes I feel a tinge of fear. Other times I feel a sense of adventure. At times, I feel a sense of relief. I have been locked up for 35 years. I am reaching the endpoint. I either be released from prison or will be released from prison on my legal claim.

When questioned about the nature of his hope to be released from prison, he stated:

I filed a petition for a writ of certiorari with the United States Supreme Court. Only a handful of applications are selected, and mine was selected. The Supreme Court gave me a docket number. They also told the State Attorney General to respond to my petition. They responded, and yesterday, my attorney and I finished my reply. My claim is straightforward; it is easy to understand.

Clarence continued that, “Since 1991, every judge and every jurist, or appellate judge to this date, they have denied my claim even though it is straightforward, it is a good claim.”

When asked who believes it is a reasonable claim, Clarence stated, “Based on two state statutes. One Statue did not include campus police as peace officers before the law was changed in August 1985; the crimes occurred in June 1985.”

When confronted with all the appeals he has submitted since 1991 to different jurisdictions and judges, he admitted that his requests had been denied. He stated, “Yes, different judges, what I say is that they are in denial. They have never given me statements of fact.”

We again discussed his history of incarceration for the last 35 years and his life before imprisonment. He reported that before he was incarcerated, he was “stupid and weak.” He continued:

“Stupid because I did not know what I had, and weak because I was gullible and easily lead astray, childish and manipulated.” He also stated, “Now I have my own sense of self. I know that when I get out, I know where to go to get help. Find a job, find a place to stay, and all that sort of stuff. I have three women, my attorney, my mitigation specialist, and my investigator. There are many women that will help me get situated there in Phoenix.

When asked about how he is different now than before incarceration, he stated:

Back then, I was beginning my adult life. And I had no value. I didn't attach any value to it. Now, I'm an older adult male. I know I only have a few years to live. And I'm not all that. I'm not ambitious. I've wasted my entire adult life in prison. If I get out, I just want to enjoy the days when I enjoy the people I come in contact with. I'm going to experience freedom.

I asked if the appeals to the Supreme Court and the multiple appeals he had done before were based on the two laws. He replied:

For the United States Supreme Court justices to rule on my behalf, they have to rule that my 1985 conviction was unlawful. And that means that my convictions back then were unconstitutional and unlawful. And that means that the convictions now were partially based on the conviction back then also become illegal, illegal or unlawful, and unconstitutional. My conviction must be overturned. And they will remand me back to the Coconino County Superior Court.

During this interview, Clarence was questioned about the voice he hears inside of his head, and he stated:

I have heard the voice for a while, almost all my life, and I have learned to put it in a bit of a compartment. The first time I heard the voice, I was in third grade on the playground, and I heard someone say ‘Clarence,’ looked around, and nobody was close to me. It was not that frequent—every 2 to 3 months. It didn't tell me to do anything bad, just saying my name.

Clarence reported that after he moved to live at a Methodist mission when he was about ten years old, he started developing an intense sense of aloneness and emptiness that he has had since. He admitted liking being alone since he was little and enjoyed reading a lot, especially about World War II. He reported that books took him to different places, like an escape. He admitted that he felt “separate” from other people and said that he enjoys “jeopardy” on his tablet.

He reports his belief that he has a tumor in his head. He also reports visual hallucinations, including seeing dead children that are watching him.

When we further discussed deathwatch and the details of isolation and being watched around the clock, Clarence reported feeling that isolation and constant surveillance is cruel punishment.

**Interview summary March 10, 2022**

The visit with Mr. Dixon started at around 9 a.m. and lasted for approximately 1 hour and 5 minutes. Our conversation focused on the issues related to his pending appeals and interaction with his legal team.

He was specifically questioned regarding the multiple appeals he has submitted and the nature of the denials. Clarence stated, "The judges and justices have never given me statements of fact and conclusions of law as to why they denied my claim." He added that "The closest they got was to tell me that the law was against me in relation to the claim of police jurisdiction." When questioned further about specific rulings, opinions of judges, and his own attorneys' views he replied: "There is no word, they just say 'We deny it.'"

I asked directly if he considered the courts' blanket denials as an indication that his arguments are correct. In response, he stated:

They can't explain it. Okay, here it is. One statute said that the NAU police or the State University Police had jurisdiction over certain crimes on campus and that stay on campus; then they have this other statute that defines who is a peace officer. Then University Police are not included in the definition of a peace officer.

And these two statutes, they were in effect, full force, and the effect was in June of 1985. They were in full effect on campus. Now, I say I tell him, okay the crime occurred, a mile and a half off-campus. They don't have the powers to investigate. To bolster my claim, they aren't even peace officers, although they call themselves police officers, they could not serve a search warrant because they were not peace officers. They were working outside of their jurisdiction.

When questioned about the judicial system's rationale for denying his claims, Clarence stated that he did not think the judges, attorneys for the state, or his own attorneys were plotting against him, but stated his belief that this reflected that they are, "Not against me but have a firm and decided philosophy that the law enforcement should always be backed up."

He stated that at one point, one of his attorneys (Vikki Liles) tried to convince him to not file an appeal on his NAU issue. When questioned about why his own attorneys do not agree with him filing appeals based on this issue he stated: "Judges are part of the bread and butter. They really can't eliminate the bread and butter. Right? Because here I am. I'm trying to push this unpopular claim. And if they push it for me, the judge may look at it unfavorably. So the next time they come with another client, that client is going to suffer because of me."

When asked about his NAU claim sounding illogical to multiple attorneys he stated:

My claim is logical. If NAU police do not have the authority to investigate crimes off-campus, and the crime occurred off-campus, then logically, they should have kept their head out of it. That means they have no power to investigate off-campus.

What I'm saying is that collectively, they have a mindset. As Arizona's judges, almost all of these judges in Arizona don't come from the public defender's side of the bar, they come from the prosecutor services bar. And that's for a reason. No wonder an FBI study done back in 1985 or '84, someone came out and said that 5% of the people incarcerated in state and federal prisons are innocent. Right? That's an awful lot of people doing innocent time. We're doing someone else's time. Doing time for somebody else's crime. It is a corrupt system. How long do you think all these black men and women were lynched in America? Decades. And then the men who got charged for the lynching are found not guilty.

When confronted with the fact that he interprets the law differently than the judges who have reviewed his NAU claim, he stated: "I have a case, I am advocating for myself using the law. I am giving the Judges the best and most favored law."

When asked if there was any possibility his interpretation of the law was faulty or incorrect, he stated:

There is no possibility at all. You can ask my attorney Amanda if my legal reasonings are incorrect. She's a lawyer and she will tell you certain things. So if my legal reasoning was not correct, why is it the United States Supreme Court wanting to look at it? All the help I need from my attorneys is assistance. I write up my own position. I give it to Amanda and she fills in the date and checks the references, and gives it back to me for signature. That is what they do. The Supreme Court is looking at my claim, and they will issue a decision before April 5<sup>th</sup>.

Clarence appears his stated age; he is medium tall and medium build and required assistance with ambulation with a cane due to blindness; however, his gait was appropriate. He was noted to be clean and well kept, without evidence of malnourishment or physical violence. He was alert and talkative, with an indifferent mood and somewhat blunted affect. He was noted to be guarded and somewhat distrustful.

His thought processes are pretty rigid and somewhat circumstantial, and his ability to problem solve appears quite limited by his distorted thinking and inability to exercise objective judgment, as evidenced by his deluded understanding of the legal process regarding his appeals. He also seems to have a deluded sense of the law as it applies to his arrest. He admits to visual, auditory, and tactile hallucinations, and his thought content seems to be contaminated by grandiosity and concreteness. His ability to exercise objective judgment appears to be quite limited and tainted by his hallucinations and thought content disturbances. His memory seems intact, but his ability to concentrate is poor.

**Diagnoses:**

- Schizophrenia Paranoid Type.
- Major Depression Disorder
- Alcohol Dependence in Full remission
- Glaucoma with Secondary Blindness
- Non24 sleep cycle disorder

**Assessment:**

It is my professional opinion, which I hold to a high degree of medical certainty, that Clarence suffers primarily from the mental disorder of schizophrenia.

Schizophrenia starts in early adulthood and is marked by premorbid and prodromal subthreshold symptoms leading up to full onset. People with schizophrenia typically have corresponding deficits in neurocognitive functioning, which persist even with medication. Schizophrenia is chronic and debilitating and affects every aspect of functioning.

Schizophrenia is a neurodevelopmental disorder. It is diagnosed based on the presence and severity of symptoms, including hallucinations, delusions, thought disorder, and negative symptoms. Symptoms are typically grouped into three domains: positive symptoms, which include delusions and hallucinations; negative symptoms, which include avolition, social withdrawal, loss of interest or motivation, and lack of hygiene; and thought disorder, which provides for impaired cognitive functioning in many areas (executive functioning, memory, attention and concentration, information processing and social cognition). Typically, the cognitive dysfunction results in unstable employment, poor relationships, and difficulty with independent living. To be diagnosed with schizophrenia, a person does not usually have all these symptoms. The presence of only positive symptoms is sufficient for diagnosis.

Schizophrenia is a complex neurodevelopmental disorder that in most individuals has a pre-illness lower than average intelligence that continues to decrease as the illness progress. However, there is a subgroup of individuals with high intelligence that tends to manifest continued high intelligence during the course of the illness and tend to manifest fewer negative symptoms. In some cases, these patients may appear normal to the untrained observer.

Based on my evaluation of Clarence and the available records reviewed, Clarence presents with both positive, cognitive, and negative symptoms of schizophrenia.

In patients who have schizophrenia, substance abuse is a common co-morbid condition. Clarence's history of substance abuse is consistent with the high rates of comorbidity substance-related disorders in schizophrenia.

**Referral questions:**

1. Is Clarence's mental state so distorted, or his concept of reality so impaired, that he lacks a rational understanding of the State's rationale for his execution?

In my best opinion, Clarence suffers from a psychiatrically determinable impairment that significantly affects his ability to develop a rational understanding of the State's reasons for his execution.

Clarence is disconnected with reality, especially as it relates to his legal case. His visual, auditory, and tactile hallucinations further aggravate his disconnect with reality. Clarence's thought process is contaminated by concrete thinking, which is common in those diagnosed with schizophrenia. Clarence's concrete thinking causes him to fixate on an issue that is unrelated to his execution, limiting his ability to abstractly consider why he is to be executed. This results in his inability to form a rational understanding of the State's reasons for his execution.

Clarence holds a fixed delusional belief that his incarceration, conviction, and forthcoming execution stem from his wrongful arrest by the NAU police in 1985. That belief has no basis in fact—since it was the Flagstaff Police, *not* the NAU police, that arrested him (FPD 7027-7029)—nor is Clarence able to grasp that this belief has no basis in fact, which renders Clarence's understanding of why he'll be executed irrational.

For decades, Clarence has fixated over and pursued this delusional belief to his detriment: He fired his court-appointed attorneys and represented himself at his capital trial after they refused to raise this factually baseless issue; and he has filed appeals over this issue nearly thirty times in numerous state and federal courts.

Despite explanations from prior lawyers and the courts for why the issue is baseless, Clarence is unable to rationally understand why he has not obtained relief on this issue.

Clarence's pro se filings reveal his delusional, paranoid, and conspiratorial thought content. He has, for instance, expressed the irrational beliefs that: his prior lawyers "purposefully exclude[ed] the [NAU] issue" (FPD 6547); courts have "refused and ignored applying relevant law" because of the nature of his crime and possibility of his release (FPD 6562); relief has been denied on this claim because "[t]he State is embarrassed that for many years [the NAU police] has operated without statutory authority[]" (FPD 6563); the courts' action on the NAU issue reflects their deliberate and "continued evasion" of his right to relief (FPD 6780); the courts have engaged in "obvious subterfuge" (FPD 6790, FPD 6952) and are purposefully in "collusion" to deny him his rights (FPD 6973-6980); that the "cumulative, continuous and concerted effort by state and federal judges on its face smacks of collusion and conspiracy or, at the least, complicity and the reader is left considering the circumstantial weight to tell if judicial collusion is found[]" (FPD 6980; *see also* FPD 6983); and that judges have engaged in deliberate "obstruction" in denying his NAU claim (FPD 6988) evidencing their "spirit of ill-will towards [him]" (FPD 7356-7357). Clarence also believes that the courts have denied his claim "because to follow and apply the law would have been politically disastrous, a dark embarrassment to the state universities." (FPD 6962.)

While Clarence can verbalize a surface awareness that the State intends to execute him for a crime that occurred in 1978 and for which he was convicted, it is my professional opinion that Clarence nonetheless lacks a rational understanding of the State's reasons for his execution. That is because, at bottom, Clarence ultimately believes that he will be executed because the NAU police wrongfully arrested him in 1985 and the judicial system—and actors in it, including his own lawyers—have conspired to cover up that fact.

As the records, Clarence's history, and my evaluations illustrate, while Clarence can verbalize an awareness of the legal process and has a limited capacity to exercise rational judgment in some areas of life, his beliefs about why he is incarcerated and why the State seeks to execute him are fundamentally irrational. His capacity to understand the rationality of his execution is contaminated by the schizophrenic process which results in his deluded thinking about the law, the judicial system, his own lawyers, and his ultimate execution despite multiple attempts over many years to disabuse him of his irrational beliefs.

2. Would Death Watch increase the likelihood that Clarence Dixon would manifest or experience a worsening of the impaired mental states described in Question 1? If so, why?

It is a well-known fact that extreme isolation of any individual leads to severe psychological and psychiatric distress; vulnerable individuals such as those with mental disorders are particularly more susceptible to decompensations.

In Clarence's case, the psychosocial and physical stress related to increased isolation, lack of any privacy, and 24-hour supervision is likely to worsen his delusional and paranoid thinking, initiate a new depressive episode, and worsen his anxiety. In the context of his blindness, deathwatch becomes a new challenge with new uncertainties that will challenge all of his acquired abilities to manage his blindness.

Under his circumstances, deathwatch isolation is analogous to psychological torture that is highly likely to lead to psychiatric decompensation.



Lauro Amezcua-Patino, MD, FAPA.

03/31/2022

Date

Lauro  
Amezcua-  
Patino MD

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Patino MD  
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OTTO L. BENDHEIM, M.D.  
CAMELBACK PROFESSIONAL BUILDING  
3051 NORTH 84TH STREET  
PHOENIX, ARIZONA 85018

TELEPHONE DUS-0200 955 1090

September 2, 1977

RECEIVED  
SANDRA D. O'CONNOR

SEP 7 1977

JUDGE OF THE SUPERIOR COURT

98107

re: Clarence W. Dixon  
Cr # 98107

The Honorable Sandra D. O'Connor  
Judge of the Superior Court, Division 29 I  
Superior Court Building  
Phoenix, Arizona 85003

Dear Judge O'Connor:

Clarence W. Dixon was examined upon your request. The examination took place at my office in Phoenix on August 26, 1977. The interview lasted for one hour and 45 minutes but due to the condition described below, the examination was not entirely satisfactory and no very definitive conclusion could be reached. For this reason the defendant was asked to return to my office on August 31, 1977. He was then given another hour and 15 minutes of intensive psychiatric interview on August 31, 1977. After spending more than the usual time with this defendant, I arrived at the following opinion:

Opinion

1. While the defendant is of normal or superior intelligence, while he is well oriented and fully aware of his present circumstances, he is so severely depressed, he blocks so much and hesitates between answers to the extent that many questions remained totally unanswered, that I feel he is at this time not able to stand trial; and while he understands the nature of the proceedings against him, he is not able to assist counsel in the preparation of his own defense.
2. While the defendant has a substantial and competent awareness of his legal rights, he cannot make competent decisions regarding the waiver of these rights. I feel that while he has a factual understanding of the consequences of entering a plea of guilty, this understanding is not rational because repeatedly during the interview the defendant said, "I just want to get sentenced. Maybe I should get sentenced and go to prison for three years," this with many tears, with suppressed sobbing and with the attitude of utter despair and desperate depression.
3. I believe that this man is suffering from very severe depression, possibly with an underlying psychosis. The exact nature of his mental illness could not be determined but a schizophrenic psychosis is considered to be the most likely diagnosis.
4. I consider it quite likely that given time and proper treatment, this defendant will become competent to stand trial within two to six months.
5. It is recommended that the defendant be admitted to the Arizona State Hospital for a period of intensive observation and therapy until his competency is restored.

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OTTO L. BENDHEIM, M. D. ... CONTINUATION

2.

Clarence W. Dixon  
609 012Opinion

6. In view of the police reports and the transcript of the preliminary precinct hearings, it is my opinion that there is a potential dangerousness to others. From my own observation, I found the defendant definitely "gravely disabled."

7. The victim of the alleged crime as well as the investigating police officer considered this man confused, disoriented and irrational at the time and shortly after the alleged offense. I would agree with this estimation of his mental condition and would further state that the possible motive, which the defendant mentioned in explanation of his act of violence, is irrational, and would indicate presence of serious mental illness.

One could conclude, tentatively, that he was not fully aware of the difference between right and wrong, not fully in control of his actions, not fully aware of the nature and consequences of these actions, and that he was unable to conform to the requirements of the law and of society at that time.

8. I have a strong feeling that without presence of the mental disturbance, the act of violence would not have taken place.

I had available background material made available to me through the courtesy of Paul Lazarus, Esq., of the County Attorney's Office. This material consisted mainly of police reports and transcript of the preliminary hearing. These were carefully reviewed and taken into consideration.

ExaminationIdentification

The defendant is a very slightly built, young adult, full blooded Navajo. He stands 5' 8", weighs only 115 pounds. He has long dark hair, wears eye glasses, has no beard. He appears quite poorly developed and the face appears quite emaciated. His expression is one of severe depression. There is much crying and suppressed sobbing during the entire interview. I believe that the defendant cooperated to the best of his capacity.

History

He told me that he was born in Fort Defiance in 1955. Both parents were full blooded Navajos. They were divorced after they had eight children. The father was a well educated high school principal, later an Educational Specialist for the BIA. He died following surgery on his legs several years ago. The mother is living and well. There are four brothers and three sisters living and well.

The defendant is not aware of any neurological or psychiatric disease within the family except that his father used to suffer from migraine headaches and consulted a psychiatrist in Farmington, New Mexico.

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OTTO L. BENDHEIM, M. D. - CONTINUATION

3.7

Clarence W. Dixon

History

The defendant states that he was the only one of the eight brothers and sisters who got along with their father. The others did not like him and for this reason, he is the only one who is trying to achieve a college education.

The defendant was graduated from high school in Fort Defiance at age 19, with average grades. He is now attending Arizona State University with the objective of an engineering degree. At the present time he is working steadily as an automobile mechanic at a service station in Chandler. He has held this job for one year. Before that he held another similar job, also for about a year.

Health He states that his own health has been poor. He had cardiac surgery apparently for a valvular defect when he was 12 years of age. He states that he made a good recovery. He has never had any fainting spells, epilepsy, head injuries or any other serious illness except for heart disease.

Legal He has had no prior experiences with legal authorities except one arrest for disturbance of the peace in Window Rock some three or four years ago, when he was drinking and making a nuisance of himself.

Marital He was married a year and a half ago. There are no children. He describes his marriage as unhappy, which is described below.

Mental Status

He is very well oriented. He knows the exact time of day, day of week, date, etc. He knows the address of the professional building, knows that I am a psychiatrist, "a person trained to analyze mental disorders." He knows that he came in order to see "if I was mentally sane."

He knows that he is charged with assault with a deadly weapon, defines this term quite correctly, and knows that this would be criminal and punishable. He has an excellent idea of the functions of judge, jury and prosecuting attorney. After hesitating a great deal, he finally gives the name of his own attorney, Mr. Balkan. He hopes that he can trust him but, after long hesitation and much urging, he tells me that he cannot tell his own attorney everything that he knows. Neither can he tell me, his court appointed psychiatrist, because it is too difficult and he just cannot talk.

He tells me however that he remembers all the incidents on that particular night. He had not been drinking, he had not been taking any illegitimate drugs, marijuana, etc.

He has an excellent understanding of the meaning of waiver of rights but I do not believe that he can act rationally upon such a decision because on several occasions he assures me that he wants to be sentenced and put into prison, that he is very remorseful, and that he is totally puzzled, bewildered, and cannot talk about what has happened.

He has an understanding of the meaning of plea of guilty, knows its consequences, "a prison sentence," but again I do not believe that he can rationally enter such a plea.

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OTTO L. BENDHEIM, M.D. - CONTINUATION

4. 7

Clarence W. Dixon

Mental Status

I tried to go over the scene of the crime again and again. The defendant is unable to open up, relax and talk about it, except as mentioned on a separate page. He did tell me however, "I was irrational that night."

The defendant displays a superior intelligence, good fund of general knowledge, excellent mathematical abilities, sufficient capacity to interpret proverbs, define differences, etc. etc.

I found no evidence of true delusions or hallucinations with the one marked exception of a possible delusional thought content at the time of the act of violence.

Throughout the entire interview the defendant spoke in a low, monotonous voice, interrupted by sobbing and crying, and at times inaudibly low so that I had to repeat my questions frequently. Often there was a pause of one to three minutes before he could answer. Often he did not answer at all.

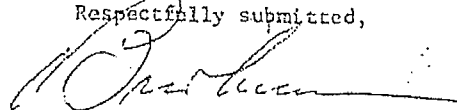
During the second interview, on August 31, 1977, the defendant was equally depressed, blocked, appeared at times retarded in psychomotor activities, and always pre-occupied with most unpleasant and sad thoughts. His facial expression was one of utter despair, the voice again very low, at times unintelligible, and he cried on several occasions.

He readily admitted to me that something was wrong with him and that he didn't know quite what it was. When I suggested that he undergo treatment for his obvious severe depression, he hesitated for a long time and then came up with his fear that if he were to be hospitalized at this time, it would curtail his progress in college and he may lose an entire semester. I indicated to him that in his present condition, he could hardly be expected to perform well in engineering school, whereupon he answered that somehow he feels he could handle his studies, this not brought forth with a great deal of conviction, and again was interspersed with sobbing, hesitation, ambivalence, doubtfulness and uncertainty.

When I asked him to go again over the alleged crime, he made a statement very similar to the one given on a separate page, which he had made during the previous interview.

He again talked about the unhappiness in his marriage, the fact that he had considered divorcing his wife on several occasions, that while he has not displayed any violence in her presence nor had any intent to hurt her, nevertheless he did not consider it impossible at all that a substitute for his wife, for instance the victim who was totally unknown to him, could have served as an object of his suppressed despair, anger and disappointment in his wife.

Respectfully submitted,



OTTO L. BENDHEIM, M. D.

OLB:d1

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5.

Name Clarence W. Dixon77 009 Date 8/26/77

016

COMPETENCY TO STAND TRIAL

1. Does the defendant have the mental capacity to appreciate his presence in relation to:

- A. Time 11:30 AM, Friday, August 26, 1977
- B. Place Professional building in Phoenix
- C. Person You are a psychiatrist, a person trained in analyzing mental diseases
- D. Things to see if I was mentally sane

2. Are his mental processes such that he apprehends that he will be in a court of justice charged with a criminal offense? yes

- A. What is the charge? assault with a deadly weapon
- B. Definition assault - striking someone  
deadly weapon - any object that could inflict harm upon a person
- C. Is this a crime? yes
- D. Is it punishable? yes

3. Does he apprehend that there will be a judge on the bench? yes

- A. What is his function? To see that justice is carried out for both sides

4. Does he apprehend that a prosecutor will be present who will try to convict him of a criminal charge? yes

- What is his function? to defend the State and the innocent

5. Does he apprehend that there may be a jury present to pass upon evidence adduced as to his guilt or innocence of such charge? yes

- What is its function? they make the final decision whether a person is guilty or not guilty

6. Does he apprehend that he has a lawyer who will undertake to defend him against that charge? yes

- What is his name? Mr. Baikan

001331

6.

Name Clarence W. DixonCOMPETENCY TO STAND TRIAL

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7. Does the defendant believe that he can trust and confide in his lawyer?

Yes

8. Does the defendant apprehend that he will be expected to tell his lawyer the circumstances and the facts surrounding him at the time and place where the law violation is alleged to have been committed, to the best of his mental capacity (whether colored or not by mental aberration)?

Long hesitation -- I don't want to tell him everything

9. Does the defendant have memory sufficient to relate those things in his own personal manner?

yes

A. Was he intoxicated?

no

1. How much did he drink?

nothing

2. In what period of time?

3. Had he eaten during the 12 hour period prior to the event?

yes

B. Was he under the influence of alcohol?

no

C. Was he under the influence of drugs?

no

1. Name of drugs

none

2. Quantity

3. Time of consumption

## 10. Waiver of rights

A. What is meant by waiver of rights?

when you push away your rights

B. Do you know that you do not have to talk to me about the events leading to the charges?

yes

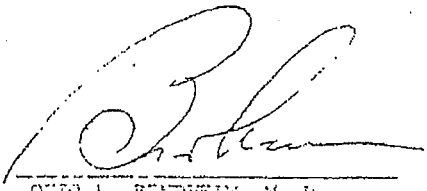
C. If you choose to talk to me about this, do you know that your statements will be quoted in my report to the court?

yes

11. What does a plea of guilty mean?

It means to admit that you have done something wrong.

12. What are the consequences of entering a plea of guilty? a prison sentence

  
 OTTO L. SONDEHM, M. D.

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OTTO L. BENDHEIM, M. D. . . CONTINUATION

7 0 0 9 Clarence W. Dixon

Defendant Statements pertaining to events leading to charges

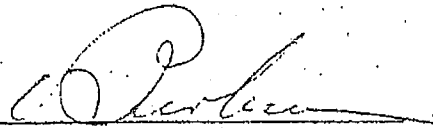
The following statements were made by the defendant voluntarily, knowing that his remarks would be quoted to the court. He understood that he did not have to talk to me about the events.

The defendant stated that on the night of June 4 he felt quite bad. He had had difficulties with his wife, particularly since the visit of her little nine year old brother. The defendant felt that in the presence of her brother, his wife had tried to be a fine wife, an exemplary housekeeper etc., but when there were no witnesses, she would treat him, the defendant, like a little puppy or infant. She would just sit around the house reading, sleeping, doing nothing, some times not even cooking for him. "She would just do nothing."

He was particularly irritated with her and on that particular day, he had had a fight with three customers, a fight which he had provoked. He had told one of the customers that he considered him stupid because the customer asked where he should put the oil into his car. After the defendant called him stupid, the customer called him a dumb Indian, was sarcastic and the defendant began a fight with all three of them. He was beaten up by the three.

Later on at midnight, he left his service station at the termination of his work, but instead of going home, he drove around; then parked silently somewhere in the neighborhood; then proceeded to drive again; got out of his car, took a metal pipe into his pocket, and when he approached the victim, whom he did not know at all, he made an innocent remark to her and then hit her over the head.

When I asked him how he could explain this, there was a long pause of perhaps two minutes. He could not talk, just sobbed and cried, then came out with the following statement, "Some times I keep thinking that this girl was my wife. Maybe subconsciously I wanted to hit my wife. She does not do anything, she sleeps and sits around." He then gives an expression of extreme unhappiness, again blocks, is unable to talk, unable to make any further statements.

  
OTTO L. BENDHEIM, M. D.

001333

MAIER I TUCHLER, M.D.  
4400 NO 38<sup>TH</sup> STREET  
PHOENIX, ARIZONA 85018  
955-6470

September 2, 1977

FILED  
SEP 14 1977  
By *B. Barnes*  
VILSON J. FLETCHER, Clerk  
RECEIVED  
SANDRA D. O'CONNOR  
SEP 15 1977  
JUDGE OF THE SUPERIOR COURT

The Honorable Sandra D. O'Connor  
Judge, The Superior Court  
Maricopa County Courthouse  
Phoenix, Arizona 85003

Re: Clarence W. Dixon  
CR: 98107

Dear Judge O'Connor:

Clarence Dixon presented at this office in the afternoon of August 29, 1977, for psychiatric evaluation pursuant to your authorization. The following is a report.

Clarence Dixon is a twenty-two year old Navajo, born at Fort Defiance August 28, 1955. He was educated at Window Rock High School between 1971 and 1972, with further training at Huntington Park night school when working in Los Angeles as a gas station attendant in 1972 to 1973. He returned to Chinle where he lived with his mother, attended Chinle High School and graduated in 1974.

The above brief resume was reported in a soft spoken voice which could hardly be heard, with much blocking. He spoke in monosyllables and although the material above presented is relatively without sensitivity, he had great difficulty in reporting even so brief a history.

He moved with his mother to Tryea from Chinle after his father died in 1975. His father was a teacher in Chinle. Clarence is the fourth of a sibship of eight.

As a boy of twelve he was treated at Children's Hospital in Phoenix for heart murmur and underwent cardiac surgery.

Since the Summer of 1976 he has been attending A.S.U. and is starting his sophomore year. He is living in Tempe with his wife at 950 South Terrace Road. He married in 1976. His wife is a Navajo whom he met at Window Rock. The above few paragraphs were obtained with great difficulty and it was equally difficult for the patient to report that he had been involved in disturbing the peace in Window Rock. He was arrested for disturbing the peace while intoxicated at a friend's home.

He recognizes that he becomes personally disturbed when drinking which leads to his spontaneous comment that his wife states he does not care about anything or anybody. He describes many bouts with loneliness and on June 5th, he reported he had had a bad day at work. He works at a service station between three and eleven o'clock, in Chandler, a job he has held since August of last year.

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Clarence W. Dixon.

-2-

September 8, 1977

He got into a quarrel with a Chicano when out in a tow car, pulling a broken down vehicle to the station. He was on his way home when the incident occurred. He states he didn't feel like going home although he does not know what got him upset. He pulled off a side street and parked. He sat in the car for fifteen minutes he recalls, stating "It was a nice night."

He does not know why he put a pipe in his pocket and walked. He related the facts of the incident quite as he had reported them to the police. As he reports his history, in those areas of sensitivity, he blocks and breaks into tears.

It becomes obvious that he has had difficulties with his marriage. She wanted him to live at home and on one occasion he went to the gas station where he stayed over night. His wife broke windows in their apartment and called the police on him when they were having a fight. He states, "It was all saved up, all my anger."

There is no immediate history of drugs involving alcohol, the usual psychedelics or l.s.d. While living in Los Angeles he tried cocaine, barbiturates and marijuana but there is no evidence of drug intoxication prior to this reported incident.

In reviewing the Justice Court transcripts of June 22, 1977, the arresting officer, Mr. Philip Cicero, reported the patient seemed confused but could not give the officer a reason why he did it.

On this date Mr. Dixon is able to review the Constitutional rights waived on entering a plea of guilty which were read to him, and he was able to respond with a moderate degree of blocking but certainly with comprehension of the consequences of entering such a plea of guilty, on both a rational as well as a factual basis.

He understood he was to appear before a Judge, before a jury with prosecution and defense attorneys pleading each side of the alleged assault with a deadly weapon for which he is charged.

Clarence is a college level student but it is extremely difficult to understand through this examination, the degree of his emotional difficulties for the mental status examination reveals several characteristics which are clearly abnormal. Although he is oriented for time, place and person, and is fairly well educated, he is exceedingly slowed in responses, markedly withdrawn and obviously depressed. Blocking is characteristic and has prolonged the interview interminably.

As the patient reports on his relationship with his wife, his contents become somewhat bizarre and it is the opinion of this examiner that Clarence Dixon was under the delusory belief that the victim, Christy Guerra, may have been identified in his mind as his wife. In other words, he was slashing out at a stranger while responding to fantasies that he was attacking his wife.

His marriage is indeed in a stormy situation and much rage is felt toward the wife although he has great difficulty expressing it. It is the opinion of this examiner that at the time of the commission of the offense Clarence Dixon was presenting a transient mental illness in which reality was lost to him, and he presented as an undifferentiated schizophrenia.

I would thus feel that he is not now competent to stand trial although he is able to

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Clarence W. Dixon

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September 8, 1977

understand the nature of the proceedings against him he cannot assist counsel in the preparation of his defense. At this time he presents symptoms of undifferentiated schizophrenia, in partial remission.

He remains depressed and is markedly blocked and has great difficulty controlling his tears. His affect is flat and it is exceedingly difficult to make contact with him. This is the type of case where a second and a third interview are frequently needed as well as an interview with the patient's kinfolk.

Lacking this latter opportunity, I would urge that he be evaluated at the State Hospital for I would consider him dangerous to self and probably gravely disturbed. That he has been dangerous to a fifteen year old is in evidence.

This undifferentiated schizophrenia is the cause of the incompetency. The defendant may become competent to stand trial after reasonable treatment at the State Hospital as recommended in view of his therapeutic needs and potential danger to the community.

Very truly yours,

*Maier I. Tuchler M.D.*  
Maier I. Tuchler, M.D.

mit:mgf

001326

ARIZONA DEPARTMENT OF CORRECTIONS  
Arizona Correctional Training Facility  
Route 7, Box 777  
Tucson, Arizona 85777  
Telephone (602) 294-3451

DATE TESTS BEGUN 23APR1981  
DATE TESTS COMPLETED 23APR1981  
DATE OF REPORT 28APR1981

NAME: Dixon, Clarence Wayne 38977 ISSUE: P-12 FILE NUMBER: ARIZACTF-127  
AGE: 25 GENDER: MALE REFERRED BY:

## PSYCHOLOGICAL REPORT

This 25 year old prisoner is here evaluated from a mental health standpoint; thus the focus and language of this report are directed toward such a context.

### INTELLECTUAL FUNCTIONING

Inmate Dixon achieved an IQ of 106, a level of functioning best described as high average. (For full listing of tests and scores, see technical appendix.) Psychosis may be producing inefficiency of intellectual functioning; the prisoner may be more competent than the IQ data imply.

### TEMPERAMENT AND HABITS:

Inmate Dixon is a highly introverted person who seeks stimulation from his own thoughts and feelings. His friendships are likely to be few, long lasting and quite deep. The pattern also suggests a pessimistic outlook on life.

The prisoner operates on an intuitive, feeling level, with much less regard for rationality and hard facts. He may find it easy to empathize, to understand, and to respond to subtleties of feelings, but can thus be easily hurt, and may err in his judgments by overdependence on intuition and on personal relationships.

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Inmate Dixon is a person who takes his responsibilities more seriously than the average person, but without excessive moralizing. Conflict with less dedicated people may be a problem, but his dependability and discipline can be desirable features.

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Dixon, Clarence Wayne 38977

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The prisoner is likely to be fairly tactful in dealing with people, but may experience some difficulty when openness and candor are required. Situations in which relations with people are on a superficial level are most congenial; those which stress expression of genuine feelings less so.

Inmate Dixon is more in tune with broad goals than with the details of their accomplishment, but not to any extreme degree. He will be most comfortable in situations where creative effort is more valued than highly objective focus.

#### MOTIVATIONAL PATTERNS:

Inmate Dixon seeks status and prestige through (usually legitimate) self assertion. Habits of status striving seem more involved than deep seated need; one may expect less concern about prestige as the situation permits or reinforces giving priority to other goals.

The prisoner is highly motivated toward career success. However, while he deeply desires vocational achievement, he has not developed the habits and daily behaviors that lead to such accomplishment. He needs opportunities, supervision, encouragement, counseling; otherwise, he will have to settle for less than the fulfillment of the career goals.

Inmate Dixon values sensual pleasure and responds strongly to sexual and romantic stimulation. Much of this orientation is at the level of desire rather than fulfillment and thus some frustration is implied. Counseling, increased sexual opportunity, or diversion of sexual energies into sublimated forms of expression all may help resolve the substantial conflict.

Looking at less intense motives that contain conflict, Inmate Dixon vacillates between independent, mature behavior and feelings of dependency upon the parents. Continuing, low level efforts to complete the emancipation process, or to accept limited dependency, can be anticipated.

#### PSYCHOPATHOLOGY

The prisoner reported grossly disturbed perceptual and thought patterns, clear paranoid ideation, feelings of frustration, and moderate agitation. The pattern of data is that most typical of a severely confused and disturbed prisoner.

#### THERAPY AND PROGNOSIS

Specific suggestions about treatment for this prisoner tend to be redundant with the report of symptoms. However, some additional factors can be reported. Since distorted thinking and perception have been rather clearly reported by Inmate Dixon, suppression of schizophrenic symptoms is quite likely to help control the disorder. Some elements of chronicity suggest a guarded prognosis with treatment.

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Dixon, Clarence Wayne 38977

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## TECHNICAL APPENDIX

The following scores have been analyzed in the preceding narrative; they are printed here for future use as a basis for assessment of change, or as an aid in addressing new issues.

## ABILITIES AND APTITUDES

ALL SCORES ARE EXPRESSED IN THE "IQ NUMBER SYSTEM" (M=100, SD=15) FOR EASE OF COMPARISON. "BAN" REPRESENTS A SCORE BELOW ALL NORMS.

CULTURE FAIR INTELLIGENCE TEST, SCALE 2: IQ = 106

SUMMARY OF ACHIEVEMENT GRADE LEVELS: READING = 12.0  
ARITHMETIC = 8.9  
WRITING = 11.7

EDUCATION COMPLETED (IN YEARS, AS REPORTED BY THE CLIENT): = 14

## SIXTEEN PERSONALITY FACTOR TEST, FORM C

Norms used = Male Inmates, Arizona

?	STEN SCORE	FACTOR	LOW MEANING	PROFILE										HIGH MEANING
				1	2	3	4	5	6	7	8	9	10	
	7	A	RESERVED				/			*				OUTGOING
	8	B	DULL				/			/	*			BRIGHT
	8	C	EASILY UPSET				/			/	*			CALM
	3	E	SUBMISSIVE			*	/			/				DOMINANT
	1	F	SOBER, SERIOUS	*			/			/				HAPPY-GO-LUCKY
	7	G	EXPEDIENT				/			*				CONSCIENTIOUS
	2	H	SHY, TIMID		*		/			/				VENTURESOME
	6	I	TOUGH-MINDED				/		*	/				TENDER-MINDED
	4	L	TRUSTING				*			/				SUSPICIOUS
	7	M	PRACTICAL				/			*				IMAGINATIVE
	8	N	FORTHRIGHT				/			/	*			SHREWD
	5	O	PLACID, SERENE				/	*		/				APPREHENSIVE
	6	Q1	CONSERVATIVE				/		*	/				EXPERIMENTING
	9	Q2	GROUP ORIENTED				/		/		*			SELF DIRECTED
	4	Q3	UNDISCIPLINED				*		/		/			DISCIPLINED
	7	Q4	RELAXED				/			*				TENSE, DRIVEN
	8	MD	OPEN				/			/	*			DEFENSIVE

ITEM RESPONSES BY POSITION: LEFT = 45, MIDDLE = 11, RIGHT = 49.

## COMPOSITE SCORES FROM PERSONALITY FACTOR DATA

ANXIETY LEVEL	5.3	INDEPENDENCE	5.1	EXTROVERSION	1.7
NEUROTICISM	6.6	BEHAVIOR CONTROL	5.7	DISCREETNESS	8
EMOTIONALITY	9.4	ACTING-OUT TENDENCY	4.6	SUBJECTIVISM	7

## VOCATIONAL INFERENCES FROM PERSONALITY FACTOR DATA

INTERPERSONAL CONTACT PREFERENCE	4.4	ATTENTION TO DETAIL	7.3
LEADERSHIP ROLE COMPATIBILITY	3.9	REGARD FOR RULES AND REGULATIONS	5.6
SCHOOL ACHIEVEMENT ORIENTATION	7.4	CREATIVE ORIENTATION	7.7
ON-THE-JOB GROWTH TENDENCY	8.8	HUM = 8	INT = 7

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Dixon, Clarence Wayne 38977

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## CLINICAL ANALYSIS QUESTIONNAIRE, PART II

Norms used = Male Inmates, Arizona

7	STEN	FAC	PROFILE										HIGH SCORE MEANING			
	SCORE		1	2	3	4	5	6	7	8	9	0	1	2	3	4
	4	D1				*			/							
	5	D2					*		/							
	7	D3							*							
-2	9	D4							/		*					
	7	D5							*							
-1	8	D6							/	*						
	9	D7							/		*					
-1	10	PA							/			*				
-2	6	PF					*		/							
-2	9	SC							/		*					
	3	AS			*				/							
	4	PS				*			/							

OVERCONCERNED WITH HEALTH MATTERS  
 DISGUSTED; THINKS OF SELF HARM  
 RESTLESS; EXCITED; HYPOMANIC  
 EASILY UPSET; FEELS DISTURBED  
 FEELS WEARY; LACKS ENERGY TO COPE  
 BLAMES SELF; FEELS GUILTY  
 BORED WITH PEOPLE; WITHDRAWS  
 FEELS GRANDIOSE, SINGLED OUT  
 CONDONES ANTISOCIAL ACTS  
 HALLUCINATES; DISTORTS REALITY  
 HAS REPETITIVE THOUGHTS & IMPULSES  
 FEELS WORTHLESS, INCOMPETENT

ITEM RESPONSES BY POSITION: LEFT = 46, MIDDLE = 31, RIGHT = 59.

## COMPOSITE SCORES

FEELINGS OF DEPRESSION	6.2	FEELINGS OF CONFUSION, INADEQUACY	8.6
OVERT DISTRESS	3.6	BIZARRE (PSYCHOTIC) THOUGHTS	7.2
ANTISOCIAL BEHAVIOR TENDENCIES	4.7	RISK OF DANGER TO THE SELF	5.6
DENIAL OF PSYCHIATRIC SYMPTOMS	4.4		

## MOTIVATIONAL ANALYSIS TEST

		PROFILE *										TOTAL CONFLICT		
UNINT	INTEG		1	2	3	4	5	6	7	8	9	10		
9	5	Ca				/	I		/		U		Career	8 10
7	3	Ho			I	/			U				Home/Parent	5 10
6	5	Fr				/	I	U	/				Fear	6 7
3	7	Na			U	/			I				Narcism	4 1
5	7	Se				/	U		I				Superego	6 4
3	5	SS			U	/	I		/				Self Sentiment	2 4
9	5	Ma				/	I		/		U		Matings/Sex	8 10
3	4	Pa			U	I			/				Pugnacity	1 5
7	9	As				/			U		I		Assertiveness	10 3
5	6	Sw				/	U	I	/				Sweetheart	5 5

\* I = Integrated  
 U = Unintegrated  
 B = Both scores same

TOTAL INTEGRATION  
 TOTAL CONFLICT

6  
 7

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ARIZONA DEPARTMENT OF CORRECTIONS  
Arizona Correctional Training Facility  
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Tucson, Arizona 85777  
Telephone (602) 294-3451

DATE TESTS BEGUN 23APR1981  
DATE TESTS COMPLETED 23APR1981  
DATE OF REPORT 28APR1981

NAME: Dixon, Clarence Wayne 38977 ISSUE: H-40 FILE NUMBER: ARIZACTF-127

AGE: 25 GENDER: MALE REFERRED BY:

# Psychological Report to Medical Staff

## LIFE STYLE PATTERNS:

Inmate Dixon is a highly introverted person who seeks stimulation from his own thoughts and feelings. His friendships are likely to be few, long lasting and quite deep. The pattern also suggests a pessimistic outlook on life which may predispose depressive feelings at critical times in the life process.

The prisoner operates on an intuitive, feeling level, with little regard for rationality and hard facts. The continuous risk of emotional insult engendered by this oversensitivity subjects the prisoner to some physiologic stress, and the pattern is unlikely to change greatly without major psychological intervention.

Inmate Dixon is a person who takes his responsibilities more seriously than the average person, but without excessive moralizing. Conflict with less dedicated people may be a problem, but his dependability and discipline can be desirable features.

The prisoner is likely to be fairly tactful in dealing with people, but may experience some difficulty when openness and candor are required. Situations in which relations with people are on a superficial level are most consensual; those which stress expression of genuine feelings less so.001165

Inmate Dixon is more in tune with broad goals than with the details of their accomplishment, but not to any extreme degree. He will be most comfortable in situations where creative effort is more valued than highly objective focus.

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Dixon, Clarence Wayne 38977

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## MOTIVATIONAL PATTERNS:

Inmate Dixon seeks status and prestige through (usually legitimate) self assertion. Habits of status striving seem more involved than deep seated need; one may expect less concern about prestige as the situation permits or reinforces giving priority to other goals.

The prisoner is highly motivated toward career success. However, while he deeply desires vocational achievement, he has not developed the habits and daily behaviors that lead to such accomplishment. He needs opportunities, supervision, encouragement, counseling; otherwise, he will have to settle for less than the fulfillment of the career goals.

Inmate Dixon values sensual pleasure and responds strongly to sexual and romantic stimulation. Much of this orientation is at the level of desire rather than fulfillment and thus some frustration is implied. Counseling, increased sexual opportunity, or diversion of sexual energies into sublimated forms of expression all may help resolve the substantial conflict.

Looking at less intense motives that contain conflict, Inmate Dixon vacillates between independent, mature behavior and feelings of dependency upon the parents. Continuing, low level efforts to complete the emancipation process, or to accept limited dependency, can be anticipated.

## HEALTH RISK PATTERNS:

Inmate Dixon stands at only average risk from stress related disorders. If symptoms of such conditions do appear, the prisoner should respond to counsel regarding conscious stress avoidance / reduction, coupled, of course, with appropriate medical management of the disease process.

Focussing specifically upon coronary artery disease, Inmate Dixon stands at less than average risk from a psychological standpoint. Thus, no remedial steps, other than appropriate medical care, seem indicated.

The prisoner seems able to give normal attention to the demands of risky situations; he does not seem "accident prone". There are no guarantees, but it seems that Inmate Dixon needs only to exercise normal caution, and is likely to do exactly that.

## MEDICAL / PSYCHIATRIC FACTORS (FOR PHYSICIAN USE):

Inmate Dixon shows evidence of substantial, generalized psychotic pathology, which tends to make his behavior withdrawn and ineffective. Anti-psychotic drugs may well improve performance and personal well-being. Since extreme paranoid ideation was also shown, a medication like "Stellazine" may be worth considering. Some arrangement to monitor possible side effects should be made. "Haldol" is likely to be an effective substitute for the phenothiazines if blood pressure is elevated, or if photosensitivity or other skin problems should arise. Substantial doses of any "major tranquilizer" may, of course, require covering dosage of anti-parkinsonian agents.

The medical suggestions above need to be considered within a framework of two major reservations, as follows:

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Dixon, Clarence Wayne 38977

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(1) While the decision logic used conforms to generally accepted psychiatric standards, it cannot substitute for the judgment of the physician who accepts and exercises his responsibility for his patient.

(2) The suggestions are based upon limited knowledge of the inmate, and upon data that can, by their nature, never be perfect.

001167

***Clinical, Forensic, Neuropsychological***

207 East Monterey Way, Phoenix, AZ 85012

Telephone: (602) 957-8822 Fax: (602) 957-0777 email: jtoma@biltmoreevaluation.com

**Neuropsychological/Psychological Evaluation**

**CONFIDENTIAL**

**Client Name:** Clarence Dixon      **Date of Birth:** 08/26/55  
**Age:** 56      **Sex:** Male  
**Ethnicity:** American-Indian/Navajo      **Language:** English  
**Referred by:** Kerrie Droban, Esq.      **Examiner:** John J. Toma, Ph.D.  
**Court Number:** CR2002-019595      **Dates of Evaluation:** 04/18; 04/19; 05/02; 06/26/12  
**Date of Report:** 06/30/12

**Reason for Referral:**

Ms. Droban, who was the attorney for Mr. Dixon, requested a full neuropsychological and psychological evaluation of her client and a report of the findings as they may relate to the planning of Mr. Dixon's defense.

**Evaluation Process:**

Mr. Dixon was evaluated and tested in semi-private rooms, in the Browning Unit, at the Arizona Department of Corrections facility. The evaluation consisted of clinical interviews and several neuropsychological and personality tests. Overall, over fourteen hours were spent in direct contact with Mr. Dixon.

**Limits of Confidentiality:**

Mr. Dixon had been informed by his attorney of the examination. He authorized the release of this report to his attorney and legal team. He was apprised of the limitations to confidentiality as a result of the disclosure of information that would indicate a danger to him or others and of my record keeping policies which conform to state and federal guidelines.

**Outside Sources of Information:**

Ms. Droban provided several documents for my review which are listed in Appendix A of this report.

**Acculturation Assessment:**

Racial, ethnic, spiritual and cultural background was taken into account when completing this evaluation. A general acculturation assessment was conducted in accord with the DSM-IV-TR - Outline for Cultural Formulation. Mr. Dixon's cultural and spiritual identity, cultural and spiritual explanations for presenting problems, cultural factors related to psychosocial environment and levels of functioning, cultural elements of the relationship between the

examiner and the client, and overall cultural and spiritual factors related to diagnosis and testing, were thoroughly examined and considered with all of the data available during this evaluation.

Mr. Dixon is an American-Indian who is affiliated with the Navajo Nation of Arizona. He was born on the reservation at Fort Defiance. His primary language is English but he stated that since he has been imprisoned he has taught himself the Navajo language (Diné Bizaard). Although Mr. Dixon reported that he has taught himself his native language, when asked if he felt he was connected to the Navajo culture, he responded, "I don't feel connected." He elaborated, "But I'm very proud that I taught myself to read and write in Navajo." He added, "When I daydream about getting out I dream about finding a place in New Mexico, near the reservation but off the reservation, and building myself a Hogan with a basement."

When asked about his spiritual beliefs, he stated that he was reared with the Methodist beliefs and generally referred to himself as a "Methodist" until his "third or fourth year of prison." He said that at that time "I started going to the sweat lodge until January of 1993 but they don't have it on death row." He reported that he is "more or less Agnostic" now in terms of his spiritual beliefs.

There were no barriers to the free exchange of information as Mr. Dixon's primary language is English. I did not see a spiritual or cultural foundation for a mental illness, nor did I see any reason, based upon his beliefs and practices, to modify any of the tests.

### **Tests Administered:**

#### **Intelligence:**

Wechsler Adult Intelligence Scale – IV (WAIS-IV)

#### **Language:**

Woodcock Johnson-III Tests of Achievement, Passage Completion Subtest  
Benton Controlled Oral Word Association Test (COWAT)  
Categorical Fluency Test (CFT)  
Boston Naming Test

#### **Sensorimotor:**

Halstead-Reitan Battery – Finger Tapping Subtest  
Halstead-Reitan Battery – Hand Dynamometer Subtest  
Halstead-Reitan Battery – Trail Making A Subtest  
Halstead-Reitan Battery – Tactual Performance Subtest (TPT)  
Grooved Peg Board (GPB)  
Handedness Questionnaire

#### **Memory:**

Rey Complex Figure Test (RCFT)  
Logical Memory Subtest of the Wechsler Memory Scale-III  
California Verbal Learning Test-II (CVLT)

#### **Tests of Effort/Malingering:**

Test of Memory Malingering (TOMM)  
Rey 15 Item Memory Test (RMT)

Clarence Dixon/2

**Auditory Perception/Attention:**

Halstead-Reitan Battery – Speech-Sounds Perception Subtest (attempted)  
Halstead-Reitan Battery – Seashore Rhythm Test  
Mesulam Cancellation Test (attempted)

**Executive Functioning:**

Wisconsin Card Sorting Test (WCST)  
Halstead-Reitan Battery – Booklet Category Test (BCT)  
Halstead-Reitan Battery – Trail Making B Subtest  
Stroop Color Word Association Test (attempted)

**Personality Tests:**

Minnesota Multiphasic Personality Inventory-2 (MMPI-2)  
Thematic Apperception Test (TAT)  
Rorschach Inkblot Test

**BACKGROUND**

Mr. Dixon reported that he was found Not Guilty by Reason of Insanity (NGRI), for a crime committed in June, 1977. He stated that he was civilly committed to the Arizona State Hospital in January, 1978 but was “never picked-up.” He was subsequently arrested and convicted for a burglary and assault. He was sentenced to five years in prison. Following this prison sentence, he was arrested and convicted of several charges related to sexual assault of a woman in 1985. While in prison, in 2002 he was charged with the murder of a woman that occurred, just two days after he was found NGRI in 1978. He explained, “I was in prison and there was a DNA match.” He was convicted of this crime and sentenced to death.

Mr. Dixon was married for 2 ½ years and was divorced while in prison in 1979. He reported no current relationship with his ex-wife and they did not have children. Both of his parents are deceased. His father died at the age of forty-eight (in 1975), from a heart condition and his mother died in 2002, at the age of seventy-six. He has three brothers and two sisters. He thought his brother Perry (age fifty-eight) lived in Phoenix. His brother Duane (now fifty-five) lives in Fort Defiance. His brother Willard (age fifty-three) resides in Phoenix, “I guess.” His oldest sister Ellen (age sixty-two or sixty-three) lives in Minnesota and his sister Lotta (age fifty-four) resides in Fort Defiance. He has not had contact with his sister Ellen since his father’s funeral in 1975. His other siblings have refused to have contact with him since his mother’s death in 2002. He said that his siblings “got mad” at him because he did not attend his mother’s funeral “but I didn’t have the money.” Mr. Dixon reported no relationships or connections to anyone outside of the prison.

Mr. Dixon was fully cooperative and open during this evaluation. His disclosures were reasonably consistent with the records that were provided for my review. The test results, given his eyesight limitations, are believed to be an accurate reflection of his current functioning.

**Early Development/Middle Childhood:**

As indicated above, Mr. Dixon was born in Fort Defiance, Arizona. When I asked him about his birth history, he responded, “My mom told me that I was a breach baby. I came out

butt first. I was born in the PHS ("government hospital"). I was born in the early morning and I was born a month premature. My mom said I was in the incubator for a month." He thought, however, that he reached developmental milestones in a timely manner but later told me that he did not speak until the first grade and that he was held-back a year in kindergarten. He also recalled that was born with a heart murmur for which he later received surgery.

Mr. Dixon said that his mother was a "homemaker" during his childhood and that his father was a teacher and eventually a principle in the school system. His father also apparently held a position as an "Education Specialist" for the BIA (Bureau of Indian Affairs) at one point in his career. Mr. Dixon described his father as "a very smart man but flawed like everyone else." He said that his father was a "Methodist" who did not drink or smoke. His father apparently was "a dissertation short of a Ph.D." He said that others referred to his father as "It" (the English word for a word they used in Diné) because he "married the prettiest girl in high school" and because the school team, which his father coached, "won the state championship." Mr. Dixon noted, however, that his father had several extramarital relationships and that he had several illegitimate children throughout the reservation. He added, "We would have toys and they would disappear. I think he was taking them to my half-siblings throughout the reservation."

When Mr. Dixon was asked about his earliest memories, he recalled, "I guess I was three- or four-years-old and my father was doing this dirt road from the house he was building - my mother's house on her land." He further explained, "My mother's father was a big shot in the army and he got a bunch of land when he retired. My mother got acres of land. My father was a public school teacher and he worked on building my mother's house evenings and weekends. My earliest memory is that I remember crying because he was leaving me behind."

Mr. Dixon initially described his early childhood as being "enjoyable, fun, carefree but nowadays troubling." He said that he had a heart condition resulting in low blood pressure to his legs. He recalled that as a child, on the reservation, "we ran all over bare foot." He elaborated, "I had big calluses on my feet. My legs and feet would hurt in the afternoons because of my heart murmur." He added, "My mother used to be always mad at me for needing to be taken to the hospital. One time she threw a Campbell's soup at me and hit me. I just ran into the tool shed." He said that he was always "treated differently" than his siblings because of his heart problem and the related problems with his legs and feet. He explained, "They [*referring to his parents*] were a little more distant. I didn't feel connected to my mother. I really didn't feel connected to anyone." He said that his siblings "weren't around" and that he spent most of his childhood doing things "alone."

Mr. Dixon said that he "feared" his father. He explained, "He had a temper. I don't remember him beating my mother but he beat us though. Not often but we knew that his word was law when we were really young. A lot of people respected him because he was a dissertation away from a Ph.D." Mr. Dixon described his father with, "He was an excellent provider but a lousy father." He said that he did "not really" feel a connection to his father. He emphasized, "I didn't feel connected to anyone." He recalled that his father saw a psychiatrist for what he believed was related to "trying to balance out his mood. My father was on drugs in the 1960's. He was an angry man. A distant man. There were times when he was friendly and loving but most of the time I was afraid of him. He was mean."

Mr. Dixon said that both of his parents frequently put him down by calling him names such as "stupid." He said his father always called him "stupid" and that his mother "just parroted him." He added, "I was pushed and pulled in both directions. You had to handle the old man a

certain way – walk on eggshells.” He described his mother as being a “passive woman.” He elaborated, “I loved her to death but I had no respect for her. I guess I dislike women because of her.” He recalled, at this time in the evaluation, “I have an anger issue - probably from my father. When I used to do stuff he used to be mad.” When I asked him for an example, he recalled, “Like when I was helping build the foundation he would call me a ‘stupid ass’ and say things like ‘don’t be doing it that way.’” He then emphasized that his father was a “big shot” because he was an “Education Specialist” for the BIA and “a lot of people thought highly of him.” The contrast between how he felt towards his abusive father and how others’ perceived his father was something Mr. Dixon appeared to still be struggling with.”

Mr. Dixon remembered that he was always hungry. He explained, “We had a beautiful Irish Setter and we went to Gallup, NM every two weeks to buy a big bag of dog food. I used to eat dog food throughout the day. My father had all this expensive stuff and yet we were hungry. He would buy cameras and stuff to pick-up women.”

Mr. Dixon said that because he was held back a year in kindergarten he was in the same classes as his brother Duane. He said that they were not permitted to learn the Navajo language in school because “it was against the law.” He stated that he performed well in school but remembered that he had to wear shoes that were “too small” in the fourth and fifth grades. He stated that because of this “both of my big toes are in-grown.” He remembered that he had to walk to the hospital, several miles on his own, for surgery and that his toes were bleeding. He recalled this event to have occurred when he was eight or nine. He also remembered that in the third grade, when he thought that he was about ten or eleven, he was “extremely depressed.” He explained, “I remember being in the playground all by myself. I had no friends. I just cried because I felt so alone. I was extremely tired and felt separated from everybody.” He recalled that he experienced this “extreme depression” twice that year. The second time was when he sat alone in a field on a concrete block. He added, “I had the same feelings.”

At around the age of ten, Mr. Dixon remembered that his family spent two summers in Hogan, Utah. He said that his father was “working toward his doctorate.” He recalled that he was given a model airplane and that he cut his finger on the blade and “I had to get six stitches.” He said that his father got mad at his mother and sister because he cut his finger. He added, “He got mad at the stupidest things.” He elaborated, “He would be screaming and yelling. He would get mad at my mom for not washing the coffee pot the right way.” He further explained, “The mood of our father affected the mood of the house.”

Mr. Dixon recalled that “around the same time” [*when he was about ten*] his father “beat the hell out of my sister in her first year of college.” He continued, “She got expelled and she spent the afternoon sitting in the station wagon. My father was trying to get my sister back in and he couldn’t get her back in so he beat the hell out of her. She leaves and we don’t see her for a dozen years.”

In the sixth grade he was sent to boarding school. He added, “I hated it.” He said that within his first three weeks he “caught lice.” He emphasized that he was told “it was against the law” to speak Navajo and he felt this to be oppressing. He recalled no other specific childhood experiences and said that he progressed in school.

*I confronted Mr. Dixon with statements in the records that indicated he made a “guillotine” and “cut the heads off of cats.” He adamantly denied this. He explained, “I played a lot with tools and stuff but I never made a guillotine and I never cut off cats’ heads. The closest thing that I ever did to hurt an animal was when I was twelve or thirteen my mom got me a microscope for my birthday. I dissected a frog and then used the microscope. The only other*

*thing I can remember is when my father gave us firecrackers to play with I caught a bullfrog and put a firecracker in his mouth. That's the closest thing I ever did that could have been sadistic. He said that this was just one of the things that the "cold case detective made up."*

### **Adolescence:**

Mr. Dixon said that at the age of thirteen he had to have heart surgery. He recalled being flown from Fort Defiance to Phoenix Children's Hospital. This was a traumatic experience for him. He explained, "After the operation I couldn't find my shoes. I was worried that dad's gonna be angry because I lost my shoes. I was in pain after the operation but that's all I could think about." He added, "That memory pisses me off. You think I would have been happy because I'm going home to see my brothers and sisters but I'm worried about my shoes. What a fucked-up way to live."

Mr. Dixon said that his father bought a trailer and he lived with his two brothers, in the trailer, when he started his freshman year of secondary school. He said that his father moved from Fort Defiance to Mini Farms because he got a job as a principle. He reported that his father left his mother and moved "eighty miles away." He recalled that his mother worked as a cook in the school. He said that his relationship with his father, at that time, was "not at all good." He recalled that he left the family in his junior year after a big argument with his father. He said that he accused his father of "setting my mom up with a job so he could leave her and that's what he did."

Following his junior year of secondary school, Mr. Dixon said that he moved to Los Angeles for a summer where he stayed with his sister. He said that his sister was the secretary for an "Indian Movement - LA Chapter" and that this was "in the mid-seventies after the movie Wounded Knee." He said that they lived in a "compound outside of LA" and he spent two-to-three months "hitch-hiking around" because "I didn't have transportation." He recalled that he had to hitch-hike to night school. After the summer with his sister he moved back to Fort Defiance to live with his mother. He said that he finished secondary school in 1974.

*When I asked Mr. Dixon about the statement in his records that he had molested his sister, he responded, "That's not true either." He said that the only thing that he could remember that would even remotely suggest that was when he was tied in the same bed as Lotta. He explained, "When we were younger, maybe six or seven or maybe younger, we used to run at the window when we were supposed to be taking naps. My mother tied me to the bed with Lotta." He said that his head was at one end of the bed and hers was at the other end but that they were both tied to the bed. He said that nothing sexual occurred.*

### **Adulthood:**

After secondary school, Mr. Dixon moved in to the trailer that his father gave to his brother Duane. He said that his father had remarried and he was "not talking to his father" at the time. He recalled that he was working at a gas station in Window Rock. In 1975 his father passed-away after a heart operation. Mr. Dixon was twenty at the time of his father's death.

Mr. Dixon married Geraldine Eagleman at the age of twenty-one, in 1976. They decided to move to Phoenix and Mr. Dixon enrolled at Arizona State University (ASU). In 1977 he was adjudicated NGRI for "assaulting a girl with a pipe." At one point during the evaluation he said that the woman he assaulted was his ex-wife. *I noted in the records that he assaulted a woman*

who "bore some superficial resemblance to his wife." He was not committed to the hospital, however, until January 5, 1978 "but they never picked me up." In September, 1978 he was convicted of burglary and assault on "a college coed in Tempe." He said that he was sentenced to prison from September of 1978 to March of 1985. His wife divorced him while he was in prison in 1979.

After his release in 1985 he went to live with his brother Duane in Flagstaff. He said that he was working for a gas station "pumping gas." He was only out for three months and was arrested and convicted for charges relating to sexual and aggravated assault and kidnapping of a "single woman." He spoke about the Northern Arizona University (NAU) Police "not really being police" which was not considered in his conviction. He brought this issue up several times throughout the sessions I had with him. In spite of this potential defense, he was sentenced again to prison. He said that in November, 2002, while he was still incarcerated, he was charged and eventually convicted for a crime that occurred just two days after he was ordered to present himself to the Arizona State Hospital as NGRI in 1978. He said that the charges were filed as a result of a "DNA match" which they found "thirty years later." He was convicted and sentenced to death. Mr. Dixon has been incarcerated, almost entirely, from 1978.

### **Education/Employment History:**

Mr. Dixon was held-back a year in kindergarten but reported no other difficulties in school. He graduated from secondary school in 1974. He said that he is now fifteen credits short from achieving a bachelor's degree. He reported that he received his Associates Degree from Pima College in General Studies. He said that he achieved this degree while he has been incarcerated.

Mr. Dixon has been incarcerated most of his adult life. His first job was "pumping gas" in Window Rock, Arizona. He was nineteen when he obtained this job. He worked for this gas station for about two years. He said that he worked for a gas station and driving a tow truck while he lived in Tempe and was attending ASU. He was working at this job when he was first arrested.

### **Substance Use/Abuse History:**

Mr. Dixon reported that started smoking marijuana at the age of fourteen. He said that he smoked the drug on a "hit and miss" basis. He explained, "I was never a regular smoker. Just once in awhile. I just smoked it with my ex-wife. I never went hard-core looking for it." He also said that he tried his fathers' "Darvon and Librium" but "they didn't do anything for me."

Mr. Dixon reported that he had a problem with alcohol. He said that he started drinking, on a "catch as - catch can" basis at the age of sixteen. He said that in 1976 he started drinking regularly, which he explained was, "probably every night." He said that in the middle of 1977 to the time when he was sent to prison in September, 1978, he drank every night and experienced blackouts "about once every two weeks or three weeks." He stated that that he "got buzzed on three beers" but that some nights he drank a bottle of vodka. He said that he blacked-out from the vodka whenever he drank it. He added, "I didn't eat much at that time."

Mr. Dixon reported an extensive family history of alcoholism and possibly abuse of illicit drugs. He said that his brother Willard drank excessively. He also reported that his brothers Perry and Willard were convicted of dealing drugs on the Navajo reservation. He said that many

of his extended family members are "drinkers." He elaborated, "Quite a few on my mother's side and my father's father was an alcoholic."

*Records indicate that Mr. Dixon previously admitted to using methamphetamine "a couple of times" and that he had condoned the use of "peyote" for ceremonial purposes although there was no indication that he actually used this drug.*

### **Sexual Development/Relationships:**

Mr. Dixon said that he is heterosexual and has only had sexual experiences with women. He reported that he was never sexually abused as a child although he recalled his first sexual experience was with an "older woman" when he was sixteen. He explained, "I hated it. She was drunk. She more or less just wanted me to take her home so she gave it to me to get a ride home. It didn't mean anything to her but I was hurt by it."

Mr. Dixon stated that he had a problem which began in 1978. He said that he had difficulty controlling his sexual energy. He has been convicted of sexual crimes related to this difficulty. When asked about the repeated sexual offenses, Mr. Dixon stated that they started when he was in his early twenties. He recalled, "I used to get drunk after work. I'd get off work at around ten and walk around sin city. I'd get home and she'd be gone to work [*referring to his wife*]. I hardly seen my wife. I was getting free booze at work [*he explained that driving a tow truck to accident scenes they would often find unopened bottles of alcohol*]. The first time I was walking around and I noticed a door was open. I went inside and the adrenaline was pumping. I saw a guy sleeping on the couch and I walked around his apartment. I took a calculator from the desk. After that I started checking doors on my night walks. If they were open I'd walk in. Once I saw a girl sleeping on her bed in her panties and a tee-shirt. I didn't do anything but that got me excited." He said that when he was having sex with women "I got aroused from the dominance and the power. I like the idea of control or dominance but I don't like to hurt. Handcuffs hurt but straps don't. I used straps."

Mr. Dixon reported no other unusual experiences except, "I remember I woke-up one morning in this girls' apartment and I don't know how I got there." During the last session, however, I informed him that some of his TAT responses were suggestive of sexual identity issues. He responded, "Well maybe the ten percent of me that is homosexual is coming out. I had these feelings when I was younger. I caught myself walking with a limp hand once and sometimes I wondered what it was like to be a girl. I don't have any identity issues now though."

Mr. Dixon has no current, human contact, outside of the prison. He has not spoken to his siblings since his mothers' death. He stated that prior to prison his relationship with his siblings was "okay." He indicated, however, that he did not feel connected to anyone as a child and still has no feelings of connectedness to anyone now. His parents were abusive (emotionally and physically) and although he "loved his mother to death," he felt that she was distant from him and not connected to him. He said that he did not feel connected to his father.

Mr. Dixon was married for 1 ½ to two years in 1976. As indicated above, he was adjudicated NGRI for assaulting his wife with a lead pipe in 1977. His wife divorced him when he was serving time in prison. He had nothing to say about that relationship other than "I had a lot of resentment" toward her.

### **Criminal History:**

Mr. Dixon reported no involvement with the Juvenile Justice System and no childhood behaviors to warrant such involvement. He said that he was first convicted of a DUI when he was eighteen. He was living in Window Rock, AZ at the time. He reported "a couple more DUI's" when he was eighteen and nineteen in Gallup, NM. He also stated that he was charged with soliciting prostitution in 1978. He said that he spent five days in jail and received a \$15.00 fine for this offense.

As indicated above, Mr. Dixon was adjudicated NGRI in 1977 (for assaulting a young girl whom he thought was his ex-wife or she looked like his ex-wife). He was never placed in the Arizona State Hospital. He reported, however, that he has been incarcerated, almost entirely, since 1978 when he was first convicted of assault.

### **Medical History:**

Mr. Dixon stated that he was born with a heart murmur and received surgery when he was thirteen. He stated that he has had five surgeries on his eyes and said that he has been diagnosed with Glaucoma in both eyes. He said that he has had a cataract removed from his right eye and that he was not blind in that eye. His vision was seriously compromised and some of the tests could not be administered. He stated that he suffers from shingles on his chest and under his left arm. He is treated with aspirin for his heart condition and is prescribed eye medication. He also thought that he might have a "urinary condition" because he has "bumps" on his stomach buttocks that are sore.

Mr. Dixon reported no history of head trauma, seizures, serious accidents or other serious illnesses.

### **Psychiatric History:**

Mr. Dixon was adamant that he does not suffer from a mental illness. He stated that he has never been treated with psychiatric medications. He reported that he was hospitalized for two months in 1977 after he assaulted a woman with a lead pipe. He said that he had to talk to two psychiatrists. He was adjudicated NGRI for that offense but was never hospitalized. When I asked him why he was adjudicated NGRI if he did not have a mental illness, he said "It was depression. A lot of depression and resentment towards my wife."

### **Mood:**

As indicated above, Mr. Dixon reported two periods of time, in the third grade, when he was "extremely depressed." He described himself as feeling "alone, distant, empty and hopeless." He said that he did not have any friends at the time. When I asked him if there was anything else going on in his life at the time, he was unable to recall anything significantly out of the ordinary.

Mr. Dixon stated that when his father died he experienced a third bout of depression. He said that he was "living by myself" in a trailer and that he had lost his job. He said that he felt "really, really depressed and suicidal" at that time.

He reported that he has been fighting depression, on and off, since his childhood. He said that the depressive episodes "come and go." He reported that he has always felt "mousy," "unassertive," "passive" and like he was a "weakling" throughout his childhood and into his adulthood. He added, "I had huge feelings of inferiority." He said that he ended up getting into a fight (racial reasons) and that he won the fight. He said that after that fight "For the first time I felt like a man. I felt whole. I was finally taking care of myself. Finally these guys were respecting me." He stated that the "chief of the yard" kept him "around" because he was "the educated one. I could write letters to the judge."

When asked how he handles these periods of depression, Mr. Dixon stated, "I fight them with exercise." He stated that he does between six- and seven-hundred push-ups a week and that he runs three-to-four miles a week "Or I walk fast for two hours." He said that he goes to the "rec pen" every chance he can get. He added, "I do lots of weight training." He said that this is not driven behavior, rather it is a way to fight boredom and depression.

When he was asked about excessive energy or other possible driven behaviors, he reported that his energy level does not change much. He said that he is "fastidious" and not "OCD" in terms of his environment. He stated that there are times when he takes everything off the floor in his cell and "cleans every corner." He said that he does this once a month or once every two months. He added, "It used to be more regular when I had long hair." He noted, however, that his socks have to be folded a certain way and "everything in its place and a place for everything." He explained, "I'm not fastidious all the time. It's just routines to occupy myself. It's prison life."

### ***Thought:***

Mr. Dixon denied the experience of racing thoughts. He said that he sometimes "giggles to myself" to change his mood. He said that when this happens he thinks about something funny from T.V., when he is depressed, to try and keep himself from being depressed. He added, "Nowadays I have depression a lot because of my eyesight. I can't read anymore so I try to keep busy with other things. We can't get books on tape and I don't have a cassette recorder and no money for a cassette player. I don't have any family support because of not being able to go to my mother's funeral." He said that he was able to work when he was in the general population but he can't work on death row. He also said that other inmates used to pay him to type Rule 32 motions and other "legal stuff" when he was in the general population but he can't do that now. He adamantly denied periods of confusion, disorganized or disturbing thoughts, paranoid ideation, and dangerous thoughts.

*It is noteworthy, however, that after he finished the Rorschach test there was an abrupt change in his mood. He was very agitated and started yelling at me that I was "trying to get into my head." It took several minutes to calm him down. When I later reviewed his test results with him and commented that several of the tests suggested paranoid ideation, he said that he sometimes feels that others are going to harm him but attributed it to being in prison. It is also noteworthy that he seemed to obsess or perseverate on some thoughts. For example, he repeatedly brought up the issue that his defense related to the NAU police was never heard. He seemed to be obsessing with this thought and it was apparently noted as problematic during his prior criminal trials. Thought perseveration appears to be a problem.*

***Perception:***

Mr. Dixon reported that he "thought" he was hearing voices" in the "late 1980's." He said that he heard his name being called ("*Clarence, Clarence*") "from a distance." He said that these hallucinations "lasted about a year or 1 ½ years and it went away." He reported no psychiatric treatment at that time, adding, "I've always refused."

Mr. Dixon stated that he keeps seeing someone out of the "corner of my eye and there's no one there or I see a mouse running across the floor." He said that these visual distortions occur about once every two or three days, usually in the evening and only since he has been on death row. He added, "I've always had an active imagination." He then spoke about being a "phase three inmate" and how he only has four "rec days" a week. He also spoke about being in the "hole" and how he had visual distortions when he was there. He thought these were all related to sensory deprivation. He denied other perceptual distortions initially but during the last session he told me that sometimes he has "lapses in time" when he sees something on T.V. and then lapses into fantasy about that "and next thing I know an hour and a half has gone by." He also talked about visions or dreams that he has about future events. He said that he has spoken to the psychologist in the prison about these and that he has been able to dream of things that actually come true later.

Mr. Dixon said that his father was treated with Darvon, Librium and Sudafed to "try and balance out his mood." He recalled that his father took these medications in the 1960's. He described his father as an "angry" and "distant" man. He was unaware of any other family member, aside from dependence on illicit drugs and alcohol, who suffered from a mental illness.

*Two Competency evaluations were completed in September, 1977 but Dr. Benheim and Dr. Tuchler. Dr. Bendheim opined that Mr. Dixon suffered from "very severe depression, possibly with an underlying psychosis. The exact nature of his mental illness could not be determined but a schizophrenic psychosis is considered to be the most likely diagnosis." Dr. Tuchler also opined that Mr. Dixon suffered from "indifferentiated schizophrenia." Both evaluators opined that he was not competent. He was subsequently sent to the Arizona State Hospital for evaluation. The discharge summary from the hospital, (dated 09/15/77) indicated a diagnosis of "Social maladjustment without manifest psychiatric disorder" and "Marital adjustment." They found no evidence of a mental illness.*

*Mr. Dixon's ex-wife was interviewed by probation for a sentencing report in 1977. She was recorded as saying that her husband suffers from severe emotional problems and that he was not compliant with psychiatric treatment. She indicated that he was prescribed Prozac.*

**TEST RESULTS****Mental Status/Behavioral Observations:**

Mr. Dixon is a fifty-six-year-old, right-handed, Navajo male. He presented in prison clothing and with good hygiene and grooming. He said that he was 5' 8" tall and that he weighed about 130 pounds. He was bald with brown eyes. There were no distinguishing tattoos. There was a noticeable impairment to his eyes. He was also missing a tooth from the left side of the front of his mouth. Mr. Dixon brought two pairs of glasses with him to correct his vision during some of the tests but they did not always work and one of the tests could not be administered. He made good eye contact and was cooperative throughout all the testing sessions. As indicated

above, he was quite agitated and appeared to be paranoid after the Rorschach test was administered. He also appeared to be paranoid at the beginning of the last session and was agitated and spoke about the detention officers monitoring him. He was easily calmed during this latter session but not after the Rorschach was administered.

Mr. Dixon was fully oriented to person, place and time. He was also generally alert and aware. At times he was hyper-alert and very attentive to what was going on outside of the room. He had no difficulty tracking the conversation. He reported no problems related to attention, concentration, or memory. There were no gross deficits observed in these areas during the interview sessions. These functions were formally tested and the results are reported in subsequent sections of this report. His speech typical for rate, tone and volume until the last session when he was angry and spoke rapidly. There were no unusual movements noted.

Mr. Dixon reported his mood to be "good" but clearly stated that he periodically combats depression related to his situation. For the most part, he presented as euthymic. There were two brief periods when he presented with what seemed to be paranoia and anger. He denied sleep or appetite disturbances. He reported no suicidal or homicidal ideation. His thoughts were otherwise generally logical, coherent and goal-directed. I saw no behaviors to suggest that he was actively hallucinating during any of the sessions but he recalled some experiences that sounded like he might perceive himself to be able to see future events.

Mr. Dixon appeared to be giving his best effort for all of the tests. He persisted with difficult tasks without complaint. He attempted every test offered, even if it was clear that he would not be able to complete the task because of his eyesight. He frequently changed his glasses to accommodate the test stimuli. All of the tests reported in the following sections appear to be either unaffected or only mildly affected by his eyesight. There were three tests that could not be administered (Mesulam Cancellation Test and Stroop Color Word Test) as a result of his eyesight problems but he attempted both.

### **Testing Environment:**

All tests were administered and scored according to the standardized procedures. Mr. Dixon brought two pairs of reading glasses and alternated between them throughout the testing sessions. There were three tests that could not be administered as a result of his visual problems (Stroop, Mesulam, and Speech-Sounds Perception). There were no auditory difficulties reported or observed. The auditory version of the MMPI-2 was also used or available to assist with visual problems, in spite of adequate reading comprehension abilities. There were no other modifications needed for the other tests.

The test scores were interpreted in light of all the data obtained during this evaluation. The testing conditions were adequate. The testing room itself was well lit, there were minimal distractions and the furniture was adequate. His hands were unshackled and unencumbered throughout the testing sessions.

### **Test Score Comparisons:**

The test manuals were used to administer and score these tests. The test results, whenever possible, were compared with normative data established by Heaton and his colleagues that was published in 2004 (Revised Comprehensive Norms for an Expanded Halstead-Reitan

Battery). The Heaton et al. norms come from a comprehensive, demographically adjusted data set. These norms utilize scores from Caucasian and African-American adults from ages 20 to 85.

For tests that could not be evaluated with the Heaton et al. norms or for tests that were not published by Halstead and Reitan, the test publisher norms were used. The Halstead Impairment Index was calculated from the scores of the seven tests that encompass that index.

### **Tests of Effort/Symptom Validity:**

#### **Cognitive Effort:**

Some of the tests administered have subscales which are similar to independently constructed tests of effort. For example, the California Verbal Learning Test-II (CVLT-II) and the Wechsler Logical Memory subtest (WMS) have forced-choice and/or, yes/no recognition subtests. These subtests are very similar to the separately constructed tests of effort/malingering. They are equally as good in terms of assessing effort and have a good foundation of normative data as well. In addition, the intelligence test itself is constructed in such a way that response variance can be used to assess effort. As a supplement to these tests which were already a part of the battery, the Test of Malingered Memory (TOMM) and the Rey Memory Test (RMT) were administered.

Mr. Dixon's score on the yes/no recognition task of the CVLT was 15/16 for hits, with one false positive. His score on the forced choice task of the CVLT was also 15/16 which was very good. These results indicate good effort. His score on the yes/no recognition task for the Logical Memory subtest was 100% and indicative of good effort.

His score on the first trial of the TOMM was 100% and no further trials were needed. His score on the RMT was also perfect.

Essentially, all of the tests of effort indicated that Mr. Dixon was attempting to do his best and there is no question as to the validity of his cognitive test results.

#### **Intelligence:**

##### **The Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV):**

The Wechsler Adult Intelligence Scale-IV (WAIS-IV) is a widely used intelligence test and the most current Wechsler Intelligence Scale available. It provides a global measure of ability and four composite scores to clarify more specific cognitive abilities. The WAIS-IV was administered and scored according to the standardized procedures as outlined in the manual. The results from this test were interpreted with caution and after consideration of all of the data obtained and available during this evaluation.

Mr. Dixon's test results and his behaviors during this test suggest that he was putting forth good effort. He approached each task in a focused and diligent manner and did not give-up on items that were difficult. He persisted until either time was up or he could not find an answer to the questions. He reported no problems seeing the test stimuli and when needed, he used one of his two pairs of glasses.

His Full Scale Intelligence Quotient (FSIQ) was found to be in the *average* range. His General Ability Index (GAI) was, however, in the *superior* range and was significantly higher than his FSIQ. This difference could be suggesting that factors other than ability were affecting

his performance on the test. The GAI removes scores related to attention, concentration and speed of processing which can be impaired by factors such as: physical problems, psychiatric conditions, medications and brain damage. It is noteworthy that on tasks where processing speed was a factor, Mr. Dixon performed well below the other subtests. This could be related to his visual problems or one of the factors noted above and not necessarily ability. The factor index scores may help explain this.

Mr. Dixon's Verbal Comprehension (VCI) score was in the *high average* range with a Perceptual Reasoning (PRI) index score in the *superior* range. These two index scores were not significantly different from each other and they indicate well-developed verbal and spatial reasoning skills. These scores are likely more reflective of his abilities than either of the other two index scores. His Working Memory (WMI) index was in the *average* range and significantly lower than his PRI and VCI. The WMI measures attention and concentration which are the precursors to new learning. Sometimes this index can be affected by psychiatric symptoms but not by vision. His Processing Speed Index (PSI) was in the *extremely low* range of functioning and significantly lower than all of the other global measures. Although there is a visual component to the subtests that form this composite score, Mr. Dixon did not complain about an inability to see the test stimuli. It is noteworthy that the stimuli for this subtest are much larger than some of the other test stimuli where no impairment was noted. Although this difference (and impairment) could be related to visual problems it is more likely reflecting brain damage.

For the individual subtest scores, there was a significant weakness noted on the Symbol Search (SS) and Coding subtests which both contribute to the PSI. These weaknesses seem to be reflecting something other than visual problems and are likely reflecting some type of brain damage. Significant strengths were noted on the Matrix Reasoning (MR), Vocabulary (VC), Visual Puzzles (VP) and Information (IN) subtests. These subtest strengths suggest well-developed verbal and spatial skills, a good command of the English language and good long-term memory for information typically acquired in school. Some of the visual details in the MR subtest are much smaller than the stimuli in both the Coding and SS subtests and Mr. Dixon performed very well on this subtest.

Overall, Mr. Dixon's cognitive abilities lie in the *average* range of functioning but this score appears to be much lower than his actual abilities, especially given the GAI score which was in the *superior* range. As discussed, his overall FSIQ was affected by impaired processing speed and by subtests measuring attention and concentration (working memory). Although his scores on the working memory subtests were not impaired, they were significantly lower than the index scores that suggest where his true abilities lie. This weakness (working memory) and the impaired processing speed scores are likely suggesting brain damage. His premorbid abilities are likely in the *high average* or *superior* range of functioning with otherwise fairly well-developed abilities across the other cognitive domains.

#### **Auditory Perception/Attention:**

The Speech-Sounds Perception Test could not be administered because Mr. Dixon could not see the score sheet adequately, even with his glasses.

The Seashore Rhythm Test was administered to evaluate nonverbal, auditory perceptual ability. This test is audio-taped and consists of a series of like and unlike musical beats. It

measures the ability to discriminate between two tonal patterns and determine if they are the same or different. Mr. Dixon's score was *moderately impaired* on this test.

These results indicate impaired attention for nonverbal information.

**Language:**

**Reading Comprehension:**

The Passage Completion Subtest from the Woodcock III Tests of achievement was administered to obtain a reading comprehension level, primarily to determine Mr. Dixon's ability to read and understand the test items in the MMPI-2 test. His abilities were more than adequate for the independent administration of this test and appeared to be at college level.

The Benton Controlled Oral Word Association Test (COWAT), a test that measures verbal phonemic fluency and the Categorical Fluency Test (CFT), a test that provides semantic cueing for word categorization, were both administered. Mr. Dixon did not appear to have difficulty following the test instructions. His score on the COWAT and the CFT were both in the *high average* range and are consistent with what would be expected given the verbal scores obtained on the WAIS-IV.

The Boston Naming test, which requires the individual to recall the names of various pictures, was also used to assess verbal fluency. Mr. Dixon's score on this test was found to be *above average* which is again consistent with his WAIS-IV verbal scores.

Overall the verbal fluency tests suggest good expressive and receptive communication skills with no impairment noted.

**Sensorimotor:**

Mr. Dixon's scores on the handedness questionnaire indicate that he is strongly right-handed and footed. Aside from one left-handed sibling, all of his family members were right-handed. His questionnaire results suggest that he likely has language and motor functions specialized within the left hemisphere of his brain which would be consistent with 70% of right-handed males.

The Trail Making Test was used to measure overall psychomotor functioning and speed. Mr. Dixon's Trial A score, which is the better of the two Trials for processing speed, was in the *mild to moderately impaired* range.

Mr. Dixon's dominant hand score on the Finger Tapping Test, which is a test of fine motor coordination and speed, was in the *mild impairment* range. His nondominant hand score was in the *mild to moderate impairment* range. It is noteworthy that Mr. Dixon had some difficulty inhibiting and coordinating finger movements for the middle finger during this task. There is some literature to suggest that difficulties with motor inhibition could be related to lesions anywhere in the brain and not necessarily reflective of specifically lateralized damage.

Test results for the Grooved Peg Board Test, which is also a test of fine motor coordination and speed, indicated, *mild to moderately impaired* performance for his dominant hand and *moderate impairment* for his nondominant hand.

Mr. Dixon's grip strength was measured with the Hand Dynamometer Test. His dominant hand score was in the *mild to moderately impaired* range and his nondominant hand score was in the *below average* range.

The Tactual Performance Test (TPT), in addition to spatial memory, also offers a measure of psychomotor speed for dominant, nondominant, and for both hands. During this test Mr. Dixon was blindfolded and asked to place wooden blocks of various shapes into a same-shaped slot on a wooden board. He completed all three trials (dominant, nondominant and both hands) of the test without difficulties observed in grasping or manipulating the blocks. It is important to note that his approach to this task was random and without a good problem-solving approach. Even when he had the benefit of both hands, he still randomly approached the task. Not surprising, his dominant and nondominant hand scores were in the *mild impairment* range of functioning. When he was able to use both hands, his score improved but still fell in the *below average* range. This test clearly did not involve vision and these results suggest that vision may not have been the issue with the WAIS-IV impaired processing speed scores.

Essentially, overall, the motor test results indicate impaired performance across all of the tests administered. His dominant hand scores were consistently in the *mildly impaired* range with *mild to moderate impairment* noted for fine motor skills. His nondominant hand scores ranged from *below average* for grip strength to *mild or mild to moderately impaired*. When he was able to use both hands to complete a gross motor task, his score fell in the *below average* range. These scores are actually consistent with the PSI score from the WAIS-IV and many of the results are totally independent of vision. With the observations made, these test results suggest a diffuse pattern of brain damage.

### Memory:

#### *Verbal Memory:*

The CVLT-II was administered according to standardized procedures and without interruptions. Mr. Dixon's free recall score for the first trial was *below average*. His score after five repetitions (fifth trial) was *average*. His cumulative learning score (sum of five trials), was also in the *average* range. His short delay score (after a distraction list) was *average* with a long delay recall score that was *above average*. These scores suggest the possibility of some difficulties with attention for which he was apparently able to compensate with repetition. His overall retention of the verbal material he was able to learn was good. As indicated earlier, his forced choice and recognition subtests scores, for this test, both indicated good effort.

Memory for the gist of two stories was tested using the Logical Memory Subtest of the Wechsler Memory Scale-III. Mr. Dixon's immediate recall of logically related material was within the *superior* range. His learning slope was in the *high average* range with a thematic content score in the *high average* range as well. The scores for this test are consistent with his

VCI scores on the WAIS-IV. They suggest, when evaluated in light of his CVLT-II scores, that Mr. Dixon is able to overcome some difficulties with attention by using contextual and/or thematic cues. As indicated earlier, his score on the forced choice subtest for this test indicated good effort.

These findings suggest that Mr. Dixon, in spite of some mild problems with attention, can learn and retain verbal information. His scores on these tests of verbal learning are consistent with what we would expect given his verbal scores from the WAIS-IV.

### ***Spatial Memory:***

Visual-spatial memory and visual-construction skills were tested with the Rey Complex Figure Test (RCFT). Mr. Dixon's score on the copy, immediate and delayed recall trials of this test were all *above average*. His scores on the immediate recall was also *average* with a delayed recall score that was *above average*. There are many details on the test stimulus and given his scores, visual problems did not appear to impact his performance on this test.

Mr. Dixon's scores on both of the TPT memory tasks (free recall and location) were in the *average* range when using the Heaton normative data. His score on the location portion of this test was, however, *impaired* when applied to the normative data used for the Halstead-Reitan impairment index. Although his scores reflect mostly adequate performance, there is some suggestion that he may have some impairment for spatial memory.

Overall, the spatial test results generally suggest adequate spatial organization and memory abilities for fine details and gross memory. His score on the spatial, localization task of the TPT was, however, *impaired* when using the Halstead-Reitan Impairment Index. These scores could be suggesting the possibility of damage to the right hemisphere.

### **Executive Functioning:**

The Wisconsin Card Sorting Test (WCST) was used to measure conceptualization, problem-solving and cognitive flexibility. It is thought to measure the functioning of the dorsolateral prefrontal cortex. Mr. Dixon completed six separate categories which is overall *average* performance. His perseverative error score was, however, found to be *mildly impaired*.

The Stroop Color Word Association Test (both Original and Dodrill versions) was attempted but Mr. Dixon could not see the test stimuli.

The Booklet Category Test (BCT) is a test that has some relationship to cognitive flexibility and problem-solving abilities. The Booklet Category Test is also a sensitive but nonspecific frontal lobe measure as well. It is thought to measure conceptualization, problem-solving and cognitive flexibility. Mr. Dixon's score was *below average* on this test.

The second portion of the Trail Making Test (B) is also a measure of cognitive flexibility in addition to psychomotor speed. Mr. Dixon's score on this test was in the *mild to moderately impaired* range of functioning.

Essentially, two of the three tests of executive functioning were impaired and the third test score was *below average* and certainly below what would be expected given the spatial and verbal reasoning index scores from the WAIS-IV. These results suggest the possibility of damage to the frontal lobes reflected by difficulties in executive functioning.

### **Halstead Impairment Index:**

The Halstead Impairment Index is a score derived from the individual's performance on seven of the Halstead-Reitan battery of tests. Included in the index are the scores from the Category Test, TPT (total score, memory, and localization scores), Seashore Rhythm and Speech Sounds Perception tests, and the Finger Tapping Test (dominant hand). Cutoff scores from six of these tests (Speech Sounds could not be administered due to visual impairment) were used to score this index.

Five of the six available scores (Category Test, TPT Total Time and Location, Seashore Rhythm, and Finger Tapping) were impaired. This was sufficient to suggest brain damage independent of the effects of potential psychiatric symptoms.

### **Neuropsychological Test Summary:**

Mr. Dixon's test scores suggest overall *average* intellectual functioning but *superior* general abilities. His verbal and nonverbal composite scores were *high average* and *superior* respectively. Attention, concentration and especially processing speed scores were significantly lower and likely resulted in the lower FSIQ from what would be predicted by his general abilities. Visual problems and/or potential brain damage were suggested as the possible reasons.

Overall, impairment was noted for the tests that measure executive functioning (frontal lobes) and processing speed. At least two of the impaired processing speed tests did not require vision (Mr. Dixon was blindfolded during one test and grip strength does not require vision) and the other tests did not appear to be affected by visual problems. In fact, observations during the finger tapping test suggested some difficulties with motor inhibition and coordination which is a good predictor of brain damage. There were other indicators of possible difficulties with attention and one score for spatial memory (primarily organization). These results suggest that Mr. Dixon may suffer from some type of brain impairment which does not appear to be lateralized. Further evaluation is warranted.

### **Personality/Behavioral:**

#### **Minnesota Multiphasic Personality Inventory-2 (MMPI-2):**

The MMPI-2 is an objective personality test, which is thought to provide information concerning both the structure and content of personality. The MMPI-2 has acceptable validity and reliability normative data as well as subscales which can assess the individual's test-taking approach. Testing conditions were good. The audio version of this test was administered due to Mr. Dixon's visual problems.

The results from Mr. Dixon's MMPI-2 were interpreted cautiously, conservatively and in light of all other data obtained. He took approximately double the time needed to complete this test as a result of his visual problems and the need for the audio version of the test. He

approached the test in a focused and task-oriented manner. He appeared to understand the importance of answering items honestly and carefully. He did not indicate or present with behaviors to suggest that he had difficulty understanding the test items or instructions.

Validity scales on the MMPI-2 indicate that Mr. Dixon may have responded with some inconsistency (VRIN-Variable Response Inconsistency scale was slightly elevated) but not to the point where the test was invalid. The other inconsistency scale (TRIN-True Response Inconsistency) was also within an acceptable range. All of the Infrequency scales (F - Infrequent Responses, F<sub>p</sub> - Infrequent Psychopathology Responses, F<sub>B</sub> - Front/Back and F<sub>S</sub> - Infrequent Somatic Complaints) were within acceptable ranges. The Symptom Validity (FBS) scale and Dissimulation Index (F-K) were also within acceptable ranges. These scales indicate that Mr. Dixon did not exaggerate, over-report, or embellish psychiatric symptoms. The Uncommon Virtues (L-r) scale and the Adjustment Validity (K-r) and Superlative Self-Presentation (S) scales were all within acceptable ranges as well. Essentially, Mr. Dixon produced a valid test protocol for a cautious interpretation.

For the main clinical scales, clinically significant and high elevations were noted on the Pd (Psychopathic Deviate), Pa (Paranoia), and Sc (Schizophrenia) scales. These scales were interpreted using the Harris-Lingoes Subscales to identify the main experiences that contributed to the elevation of each scale.

There was one main scale contributing to the elevation of the Pd scale. The scale measuring Authority Problems (Pd<sub>2</sub>) was significantly elevated. His score on the Paranoia scale indicates that Mr. Dixon is suspicious and mistrustful of others, that he is sensitive to criticism and that he may be hostile, argumentative and emotionally labile. Only one of the Harris-Lingoes subscales was elevated. The Naiveté (Pa<sub>3</sub>) was the most significantly elevated and suggests that Mr. Dixon may have unrealistically, optimistic attitudes about other people. He may be, at least initially, more trusting and he may present with high moral standards.

There were no subscale elevations for the Schizophrenia scale. The high elevation on this scale indicates that Mr. Dixon experiences a number of unusual beliefs, that he may become withdrawn, may rely excessively upon fantasy and that he may be generally sad, blue, anxious and somatic. The possibility of bizarre thoughts and/or perceptual disturbances is also indicated by this clinical scale.

For the Restructured Clinical scales, there was one significant elevation on the Antisocial Behavior (RC4) scale. This scale indicates that Mr. Dixon has had trouble conforming his behavior to the law and it reflects his years of illicit drug and alcohol abuse. Consistent with observations and the main clinical scales, it also suggests that he is mistrusting and fearful of others with the belief that others may harm him.

The Content and Content Component scales indicate that Mr. Dixon is uncomfortable in social settings (Social Discomfort/Introversion SOD and SOD<sub>1</sub>) and that he may actually be fearful of others. He tends to prefer to be alone which is consistent with his score on the Schizophrenia scale. His scores also reflect a general and perhaps over-concern with his health (HEA<sub>3</sub>) which could be a way to cope with anxiety. It could also be reflecting his ongoing visual problems and some other concerns which may be related to aging and isolation.

For the PSY-5 and Supplementary Scales, there were only two clinically significant elevations on the INTR (Introversion) and the AAS (Addiction Admission) scales. The INTR scale is consistent with Mr. Dixon's other scores suggesting that he is not comfortable in social settings and that he prefers to isolate himself from others. The AAS elevation indicates that Mr.

Dixon acknowledges that he drank alcohol and/or abused drugs too much and to the point where he perceived himself to be addicted.

The results of the MMPI-2 are consistent with the observations, his reported history and the outside sources of information. They indicate that Mr. Dixon seems to experience thought, mood and perhaps perceptual disturbances. He tends to be isolative and is generally mistrustful of others. A psychotic disorder (such as Schizophrenia) is suggested by these test results and is consistent with the observations made back in 1977 when two Rule 11 psychiatrists opined that he was experiencing a severe depression with underlying psychotic disturbances.

### **Thematic Apperception Test:**

The Thematic Apperception Test (TAT) is a projective personality test. It is thought to provide information regarding the content of one's personality. Unlike objective personality tests, there are no true/false answers, and the subject is simply asked to create stories from pictures. There are no validity indicators for this test and interpretation is based upon deviations from "typical" responses to the stimulus cards. This test was also interpreted cautiously in light of other data available during this evaluation.

Mr. Dixon understood the directions and was generally able to meet the requirements of this assessment but he required ongoing prompting to do so. He seemed to be quite relaxed in spite of the ambiguity of this test. His responses were generally logical and coherent and rich in clinical significance.

It is noteworthy that Mr. Dixon misidentified the sex of two of the characters in this set of test stimuli. This is sometimes suggestive of sexual identity issues. It is also noteworthy that his protocol was filled with themes of death, dying and pervasive loss. These types of responses suggest underlying and deep-rooted depression. Contrasting this morbidity were unusual fantasy themes where the intensity of the fantasy was not suggested by the stimuli. This contrast can be suggestive of difficulties regulating happiness as well as sadness. Sometimes this response pattern can suggest a bipolar mood disorder but in his protocol, the depression was much more pronounced.

Mr. Dixon identified the parental figures that are typically perceived in the test stimuli. Consistent with his reported history, he commented on the "role of the mother" but projected an experience that was not genuine. He also projected a son who was distant from the mother or not really connected to her. His response to the stimulus that typically elicits information about the father/son relationship was described as a "moment." Again, their relationship was disconnected and they were projected as "wondering" about the "son's future." It is noteworthy that he was unable to provide a conclusion to the story he developed; rather he left the relationship and the scene he projected unresolved.

For the individual characters, with which Mr. Dixon clearly identified, he projected them as indecisive, sad, lonely, wounded, and embarrassed with contrasting states of "exceedingly happy," "weightless," and "unencumbered." Again, this contrast in projected emotional states could be suggesting difficulties regulating extreme periods of sadness and happiness.

Overall this protocol suggests the possibility of difficulties regulating emotion; possibly resulting in extreme states of both sadness and happiness. There is some indication that Mr. Dixon may also suffer from sexual identity issues which may indicate that he has had some sexual experiences that he was not able to disclose during the interview. This was evaluated

further, given these results, during the last session and he spoke about the "ten percent" of him that is homosexual [*see sexual history section*] but denied identity issues in the present.

### **Rorschach Inkblot Test:**

The Rorschach Inkblot test is another projective personality test that was administered and scored, using Rapaport, Gill and Schafer procedures. This test is thought to provide information into the enduring structure of personality. Interpretation was made cautiously and after consideration of all the other data available during this evaluation.

Mr. Dixon became quite agitated during this test and after the test was over he was quite angry and accused me of trying to get "inside my head" and "find psychological problems." He seemed to be quite paranoid. This was likely because of the ambiguity of this test. Consistent with this, he produced, a constricted protocol with seventeen responses (fourteen is minimum and nineteen is average).

Overall form level was within the psychotic range. He had difficulty integrating form with other details of the test stimuli (such as color). Difficulties incorporating color with form is correlated with mood disturbances. There were some morbid responses which suggest difficulties with depression. He also made a number of very bizarre comments or made several responses that included symbolism which are almost exclusively given by schizophrenic patients. One of his responses (detail to whole), which included symbolism, is suggestive of serious psychotic disturbance. Approximately 53% of his responses included either a bizarre or unusual statement and/or some symbolic interpretation. About 47% of his responses were consistent with paranoid ideation. Only two of his seventeen responses were perceptions of humans which indicates social isolation and introversion which is often consistent with schizophrenics as well. Two of his responses included references to himself which clearly indicates boundary problems and difficulties perceiving reality accurately. Finally, about 30% of his responses incorporated space which is suggestive of oppositional traits.

The results from the Rorschach are remarkably consistent with the MMPI-2 and the TAT test results and the observations made during this evaluation. They suggest that Mr. Dixon experiences thought and perceptual disturbances and may have some difficulties regulating emotion (primarily depression). Social isolation and the possibility of oppositional traits were also noted in this protocol.

### **Diagnostic Formulation:**

The test results and behavioral observations suggest that Mr. Dixon suffers from mood, thought and perceptual disturbances. There are also significant cognitive impairments noted from his neuropsychological test scores. It might be easier to address these disturbances separately.

### **Mood:**

Across all three of the personality tests there is indication of depression. A fairly severe disturbance in mood, primarily depression, was also observed by the two Rule 11 evaluators in 1977. Mr. Dixon also complained that he has struggled with depression throughout his childhood, adolescence and adult life. He reported periods when he was suicidal. He also

reported a history of child abuse (emotional and physical) that would certainly provide the foundation for depression.

Mr. Dixon did not, however, endorse symptoms or behaviors associated with manic or hypomanic states although there was some indication of this possibility in the TAT. In spite of this, the most prudent interpretation of the test results and his reported history would be that he has and continues to experience bouts of depression. These bouts include a depressed mood for most of the time and weeks at a time. During these periods, Mr. Dixon has struggled with periods uncontrollable crying (primarily childhood as he did not admit to these in adulthood), difficulties focusing and suicidal ideation.

***Thought:***

Observations during testing, outside sources and the results from the current tests clearly indicate that Mr. Dixon suffers from paranoid thoughts. There is some indication from the interview that he may also experience some grandiose thoughts but these did not appear to be as obvious. The paranoid thinking seems to be independent of mood as it appeared abruptly during this evaluation and independent of any prominent mood symptoms. Essentially, the thought disorder appears to be independent of mood although the intensity of the mood disturbance could increase the paranoid thoughts.

***Perception:***

Mr. Dixon did not endorse consistent or ongoing perceptual disturbances. The visual hallucinations that he spoke of could be related to sensory deprivation and/or transitional wake/sleep states (hypnagogic/hypnopomic). His MMPI-2 test results indicate, however, that he may experience some bizarre perceptual disturbances although he did not disclose these.

***Summary:***

Essentially, there is a clear history of periodic but frequent depressive episodes that have occurred since childhood. The test data and observations (dating back to 1977) indicate paranoid ideation. Mr. Dixon would have been in his early adulthood at the time of those Rule 11 evaluations which is consistent with the onset of most psychotic disorders. Although we have no clear disclosure of perceptual disturbances, the test results suggest otherwise. At minimum, these symptoms meet DSM-IV-TR diagnostic criteria for Schizophrenia, Paranoid Type but given the repeated depressive episodes, Schizoaffective Disorder, Depressed Type should be considered. It is important to emphasize that the paranoid ideation (at minimum), persists in the absence of mood symptoms. This would preclude a diagnosis of Major Depressive Disorder, with Psychotic Features.

***Cognition:***

The results from the neuropsychological test battery indicate a diffuse pattern of brain damage of unknown etiology. His test results indicate overall psychomotor slowing as well as coordination and motor inhibition problems. For the tests that measure executive functioning (frontal lobes), deficits suggestive of possible brain damage were also noted. Finally, there were

some test results that suggested mild difficulties with attention and the possibility of some spatial memory problems. There is no history of serious head trauma or serious medical conditions that could account for these deficits. His visual problems, although considered, could not account for all of the deficits noted by his test results. Effort was clearly not an issue.

Mr. Dixon reported that he consumed alcohol excessively during his late adolescence and early adult years but he has been incarcerated for most of his adult life and the pattern of test results do not suggest a relationship between his current deficits and his abuse of alcohol. With further evaluation, the etiology might become apparent. At this point in time, however, his test results and the related deficits meet DSM-IV-TR diagnostic criteria for Cognitive Disorder, Not Otherwise Specified (NOS).

### ***Other Axis I Considerations:***

#### ***Substance Use/Abuse:***

Mr. Dixon struggled with an addiction to alcohol throughout his early adulthood. He was convicted of alcohol-related crimes, reported withdrawal symptoms (blackouts primarily), tolerance and he experienced interpersonal problems related to his drinking. He has been incarcerated since 1985 and has not had access to alcohol (or he has but has not drunk). As such, it is important to note his history of Alcohol Dependence.

#### ***Sexual History:***

Mr. Dixon has been convicted of at least three sexual offenses (rape). Although these offenses involved some form of control of the victim and in some instances physical pain, independent of the forced sexual act, Mr. Dixon reported that he does not get aroused from inflicting pain on his victims; rather he is aroused by the dominance and the power over his victims. He did not report recurring intense fantasies or urges of control or dominance. He said that typically he would be drinking, his inhibition decreased and he would become aroused while walking the streets at night. His recall of the events leading to the arousal and rape would not, however, meet diagnostic criteria for a sexual paraphilia.

#### ***Personality Disorders:***

Mr. Dixon reported no behaviors to suggest that he would have met a childhood or adolescent conduct disorder. There were some behaviors reported in the records to suggest some serious, emotional disturbances but these were isolated and not confirmed by Mr. Dixon. In spite of these possibilities, his difficulties with the law began in early adulthood and were initially related to his drinking. The sex offense convictions also did not appear until early adulthood. These two separate types of behaviors do not, in and of themselves, meet diagnostic criteria for a personality disorder although they are clearly antisocial in nature.

**Diagnostic Impression:**

Axis I		Schizophrenia, Paranoid Type
	Rule Out	Schizoaffective Disorder, Depressed Type
		Cognitive Disorder, NOS
	History of	Alcohol Dependence
Axis II		No Diagnosis

**Legal Considerations**

**Trial Competency:**

***Current State of Competence:***

Mr. Dixon cooperated with me throughout the testing. He did not require an excessive amount of external support to remain focused and complete the tasks. During the last two sessions, however, there were two periods when he was quite paranoid and agitated.

Mr. Dixon suffers from a serious psychotic disorder. He is able to control his symptoms because he is in a very confined living space with little, other, direct human contact. During trial proceedings, he is likely to decompensate without psychiatric treatment. He should be monitored closely for competency issues currently as they were quite apparent in past proceedings (he fired several attorneys, his competence was questioned once in 1978 and he was adjudicated NGRI in 1978 as well) but not always addressed. He has made it clear that he does not want to present mitigation and this could result in difficulties assisting counsel in his current Post-conviction case.

***Competence in 2002:***

Two Rule 11 doctors evaluated Mr. Dixon in 1977 and found him to be incompetent to stand trial. He was subsequently found to be Not Guilty by Reason of Insanity. In 2002 his competence to stand trial was not questioned in spite of his inability to cooperate with several attorneys. His competence to represent himself was not questioned. Mitigation was not presented at sentencing. He was clearly not capable of representing himself and his competence to proceed should have been questioned, especially given the fact that he was not treated for his psychiatric disorder, the main symptom of which is paranoid ideation. This was likely the reason he was unable to work with his attorneys at that time and there should have been an evaluation of his ability to make rational decisions to waive his right to an attorney.

***Mental Status at the time of the Offense:***

Mr. Dixon could not recall the events in 1978 (murder of Deana Bowdoin) which resulted in his conviction and death sentence in 2002. He was unable to contribute information and the police reports or summary of the crime scene did not provide much information regarding the state of mind of the offender. His mental status should have been questioned, however, as he had

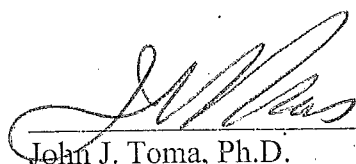
been adjudicated as "insane" just two days prior to the offense in question and he was ordered into the Arizona State Hospital. He was not receiving any psychiatric treatment at the time the offense in 1978 occurred. It is clear now, with the test data obtained during this evaluation, that the Rule 11 evaluators for his first conviction in 1978 were accurate in their opinions that he suffered from a psychotic disorder. He would have been, at the time of the murder of Deana Bowdoin, in the early stages of a schizophrenic disorder.

**Recommendations:**

Mr. Dixon should be evaluated by a psychiatrist for possible benefits of psychotropic medications. He should be monitored closely for irrational and suicidal thoughts and behaviors. He should also be monitored closely for any deterioration in his mental state as he could become paranoid, agitated and uncooperative.

Ms. Droban may wish to consider neuroimaging as the cognitive test results are suggesting a diffuse pattern of brain damage. An MRI might be appropriate for this client and may assist in understanding the etiology of the cognitive deficits noted in the neuropsychological test results.

I hope the information contained in this report is helpful to you as you plan for Mr. Dixon. If you have any questions, please feel free to contact me directly.



John J. Toma, Ph.D.

Licensed Psychologist -- Arizona

## Appendix A

State of AZ, Presentence Investigation	dated 10/05/78
Superior Court of AZ, Sentence – Prison	dated 11/02/78
AZ Board of Pardons and Paroles	dated 06/01/83
Superior Court, Flagstaff, AZ, Transcript of Proceedings	dated 12/17/85
Superior Court, Appeal Filed	dated 03/19/87
Codis DNA Match Data Response	dated 05/02/01
Complaint vs. Judge Michael Flournoy	dated 03/12/02
Superior Court of AZ, Reporter's Transcript	dated 11/26/02
Superior Court, Petition for Review in Supreme Court	dated 03/06/03
Inmate Grievance Form – Missed a meal	dated 01/05/05
Psychological Evaluation, Steven R. Gray, Ed.D, P.C.	dated 06/16/05
Letter from Mr. Dixon to Mr. Carr and Mr. Countryman	dated 08/09/06
Letter to Garrett Simpson, Esq. from Clarence Dixon	dated 09/27/06
Request for Expenditure of Funds	dated 12/07/07
Request for Expenditure of Funds, Nathaniel Carr	dated 09/07/07
Request for Expenditures of Funds	dated 10/12/07
Conference Setting Trial, Minute Entry, Oral Argument Set	dated 11/06/07
Pro Pre Defendant or Constitutional Rights	dated 11/30/07
Clarence Dixon	dated 12/13/07
Subpoena to Carron Bigel Pietkoewicz	dated 12/13/07
Miscellaneous Subpoenas	dated 12/13/07
Superior Court, Subpoenas	dated 01/08/08
Letter to Mr. Carr from Mr. Dixon	dated 02/07/08
Superior Court, Motion to allow Petitioner to proceed Pro Se	dated 02/07/08
Superior Court, Nunc Pro Tunc Correction	dated 03/03/08
Slip Listing, Kenneth P. Countryman, PC	dated 03/04/08
Superior Court of AZ, Order allow contact visit with petitioner	dated 04/02/12
Apache Elementary (School Records)	for 1964
Arizona State Hospital	from 09/15/77 to 11/02/77
Superior Court of AZ	from 06/05/77 to 11/09/81
AZ Department of Corrections, Adult Parole Services	from 02/15/85 to 05/31/85
Cold Cases	from 10/23/19 to 01/22/02
Tempe Police Report	from 09/18/78 to 09/30/02
Criminal Court Case Information, Case History	from 11/26/02 to 12/20/02
Tempe Police Report	from 04/26/96 to 04/07/03
Department of Health Services	from 08/23/57 to 10/24/03
Completed Juror Questionnaires	from 11/13/07 to 11/14/07

## **Metropolitan Consulting Corporation, PC.**

**Lauro Amezcua Patino, MD, FAPA**

4055 W. Chandler Blvd. Suite 5

Chandler, AZ 85226

480-464-431

480-464-2338 (Fax)

Patient Name: Dixon, Clarence  
Age: 57  
DOB: 08/26/1955  
Sex: Male  
Ethnicity: American Indian  
Date of Evaluation: September 7, 2012  
Court Case Number: CR2002-019595  
Referral Source: Kerrie Droban, ESQ.  
Psychiatrist: Lauro Amezcua-Patino, MD.

### **Psychiatric Evaluation**

Patient referred for psychiatric evaluation by his Attorney Ms. Droban, for a diagnostic psychiatric evaluation. Mr. Dixon was informed of her attorney's request for evaluation and limits of confidentiality, and he provided a verbal informed consent for the evaluation.

#### **Method:**

Mr. Dixon was evaluated by this writer at the Arizona Department of Corrections facility in Florence Arizona, In the Browning Unit for approximately 2 hours for a Clinical Interview and verification of history. Review of extensive records including psychiatric evaluations dating back to 1977. Review of Neuropsychological evaluation by Dr. Toma.

#### **History of Present Illness:**

Mr. Clarence Dixon is a 57 y/o, American Indian, currently residing at the Browning Unit of the Arizona Department of Corrections in Florence, Arizona. Mr. Dixon reported chronic symptoms of depression on and off since his incarceration, and at least 3 distinct episodes of severe depression in his lifetime before incarceration, manifested by decreased energy, sadness, decreased motivation, decreased interest, feelings of helplessness, hopelessness and worthlessness.

He reported at least one period of time while incarcerated when he experienced auditory and visual hallucinations.

Mr. Dixon has a documented history of being guarded and easily frustrated; was diagnosed as suffering from a thought disorder in 1977 that rendered him NGRI in 1977. However when confronted with his paranoid ideation he becomes quite defensive and irritable. Currently he reports no difficulty sleeping, and an average appetite, admits to continued feelings of hopelessness and hopelessness, and expressed strong distrust toward detention, authorities and Government officials due to his perception of being discriminated because of his ethnic background. Denied symptoms that would meet criteria for Mania, Generalized Anxiety Disorder, OCD, Dissociative disorders, Dementia, Panic Disorder.

#### Past Psychiatric History and Substance Abuse"

Mr. Dixon was evaluated psychiatrically in 1977 by 2 independent psychiatrists and diagnosed as suffering from depressive and psychotic symptoms most likely resulting from a schizophrenic process. Mr. Dixon is currently not receiving any active pharmacological psychiatric intervention.

Mr. Dixon admits to using drugs since age 14, starting with Marijuana, and abused some of his father's anxiety and pain medications. Admitted to a history of blackouts whenever he drank vodka.

#### Medical History:

He was diagnosed with a Coarctation of the Aorta corrected surgically around age 13 at Phoenix Children's Hospital. He suffers from severe Glaucoma with progressive blindness. No history of seizures, stroke, head injuries, epilepsy or other neurological disorders reported.

#### Family History:

Mr. Dixon reported an extensive family history of alcoholism and drug abuse, and 2 brothers were convicted of drug dealings on the Navajo reservation.

#### Psychosocial History

He is originally from Fort Defiance Arizona, reportedly was born 1 month premature. Father was a teacher with the Bureau of Indian Affairs and mother stayed home. Reportedly he was held one year back in kindergarten, and admitted to having experienced severe depression around age 10 or 11.

He described his father as being easily angered, physically abusive and easily frustrated. Mr. Dixon was reportedly sent to a boarding school and in the 6<sup>th</sup> grade. He moved out after his junior year in High School after having had a serious argument with his father, and spent the summer in Los Angeles, CA with his sister. He denied any history of sexual abuse or sexual abuse perpetration. His father passed away in 1975.

Mr. Dixon married in 1976 and moved to the Phoenix Metro Area, and enrolled at Arizona State University. In 1977 he was adjudicated Not Guilty for Reason of Insanity for assault, and wife divorced him while he was in prison between September 1978 and March 1985, sentenced for assault and burglary.

Allegedly, 3 months after his release of prison he was arrested and convicted for aggravated sexual assault and kidnapping in Flagstaff where he was residing with his brother Duane after release from prison.

In 2002 he was convicted via DNA match for a crime that allegedly occurred in 1978 before his NGRI visit to the Arizona State Hospital and sentenced to Death.

#### Mental Status Examination:

Mr. Dixon appeared his stated age, he is medium tall and thin built, and initially during the interview he was noted to be quite irritated, distrustful and frustrated, without being physically violent and was not sure if he wanted to discuss his history with this writer. Eventually after 4-5 minutes of conversation he became more cooperative and less guarded, he apologized and stated that he was upset that the detention officers brought him into a small detention cell about 1 hour earlier and that they were doing it on purpose, to bother him. During the interview he was noted to be guarded and somewhat talkative, with some degree of confabulation, and over inclusive with his answers. His affect was intense with a somewhat anxious and restless mood. At times he was noted to be distrustful and paranoid, in particular when discussing prior psychiatric history. His associations were logical with over inclusive stream of thought, at times circumstantial. His thought content was somewhat hopeless and angry toward detention officers because of his perception of being constantly watched; and a mild to moderate degree of ideas of reference. He was well oriented to time, place, person and circumstances, and aware of recent social and political events. His memory appears to be intact, he appears to be of average to above average intelligence, his insight is poor, and his ability to exercise objective judgment is intact.

#### Summary of Dr. Toma's Neuropsychological Test:

1. Overall average intellectual functioning and superior general abilities.
2. Low concentration, attention and processing speed.
3. Overall improvement for the tests that measure executive function.
4. MMPI is concurrent and consistent with his history of mood, thought and perceptual disturbances, and suggestive of a Schizophrenic Process.
5. TAT suggests the possibility of difficulty regulating emotions.
6. Rorschach was remarkably consistent with the MMPI and TAT with evidence of mood and thought disturbance with difficulty regulating emotions.

*These results suggest that Mr. Dixon may suffer from some type of brain impairment which does not appear to be lateralized.*

Diagnoses:

- I: Schizophrenia Paranoid Type, Chronic.  
Major Depression recurrent  
Alcohol Dependence in Full remission
- II: None
- III: Glaucoma with Secondary Blindness
- IV: Extreme, mostly enduring circumstances (death penalty)
- V: 59 current, 59 last year.

Discussion:

Based on the review of all available records, prior psychiatric evaluations, progression of symptoms, current psychiatric symptoms and neuropsychological findings, it is my best professional opinion, with a high degree of medical and psychiatric certainty that Mr. Dixon suffers from chronic and severe psychiatrically determinable thought, cognition and mood impairments that are expected to continue for an indefinite period of time of a Schizophrenic nature, complicated with depressive symptoms and historical alcohol dependence.

Schizophrenia is a chronic, severe, and disabling brain disorder that affects about 1 percent of the world population. People with the disorder may hear voices other people don't hear. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. Schizophrenia affects men and women equally. It occurs at similar rates in all ethnic groups in the world, Symptoms of hallucinations and delusions usually start between ages 16 and 30, and Men tend to experience symptoms a little earlier than men.

The symptoms of schizophrenia fall into three broad categories: positive symptoms, negative symptoms, and cognitive symptoms. Positive symptoms are psychotic behaviors not seen in healthy people. People with positive symptoms often "lose touch" with reality. These symptoms can come and go. Sometimes they are severe and at other times hardly noticeable, depending on whether the individual is receiving treatment. Negative symptoms are associated with disruptions to normal emotions and behaviors. These symptoms are harder to recognize as part of the disorder and can be mistaken for depression or other conditions. Cognitive symptoms are subtle. Like negative symptoms, cognitive symptoms may be difficult to recognize as part of the disorder. Often, they are detected only when other tests are performed. Cognitive symptoms include the following: Poor "executive functioning" (the ability to understand information and use it to make decisions), Trouble focusing or paying attention, Problems with "working memory" (the ability to use information immediately after learning it). Cognitive symptoms often make it hard to lead a normal life and earn a living. They can cause great emotional distress.

Mr. Dixon exhibits evidence of positive, negative and cognitive deficits associated with schizophrenia, with a predominance of paranoid ideation and cognitive difficulties as defined by Dr. Toma's report

Mr. Dixon is likely to benefit from a period of treatment that should include antipsychotic medications and antidepressants, with the goal of facilitating decrease of symptoms and development of more adaptive and less destructive coping.

As suggested by Dr. Toma, a more comprehensive neuropsychiatric assessment that may include an MRI, PET scan and Quantitative Electroencephalography with LORETA localization may be helpful of further rule out any other potential neurological conditions.

Thank you for the opportunity to evaluate this challenging and unfortunate individual, if I can be of further assistance, please do not hesitate to contact my office.

Respectfully

A handwritten signature in black ink, appearing to read 'Lauro Amezcua-Patino', written in a cursive style.

Lauro Amezcua-Patino, MD, FAPA.



## IN THE SUPERIOR COURT

OF

MARICOPA COUNTY, STATE OF ARIZONA

CHANGE OF VENUE	
JURY FEES	
IDS	
FINANCING	

January 5, 1978  
DATEHON. SANDRA D. O'CONNOR  
JUDGE OR COMMISSIONERWILSON D. PALMER, Clerk  
Lucy Martinez Deputy

STATE OF ARIZONA

vs

CLARENCE WAYNE DIXON

County Attorney  
by: Paul Lazarus

Adult Probation Office

Public Defender  
by: Peter Balkan

Maricopa County Sheriff's Office

Arizona State Hospital

98107

This is the time set for Rendition of Verdict. Paul Lazarus, Deputy County Attorney, is present for the State. Defendant is present with Counsel, Peter Balkan. David Minder, Court Reporter, is present.

Defendant's Exhibit 5 is marked for identification and is stipulated directly into evidence - Original four-page report of Dr. Otto L. Bendheim.

This matter having been submitted to the Court for Rendition of Verdict based on Exhibits in evidence, Exhibits 1 through 5, and Defendant having waived trial by Jury, and this matter having been under advisement until this date, and the Court having considered all of the evidence submitted,

IT IS ORDERED finding Defendant not guilty by reason of insanity.

IT IS ORDERED directing the County Attorney, Civil Division, to commence civil committment proceedings within ten days of this date in accordance with the statutes of this State, Arizona Revised Statutes, Section 36-501, and following, that a certified copy of this order is sufficient compliance with A.R.S. 36-501 to begin such proceedings.

Defendant may remain released pending civil proceedings.

*Sandra D. O'Connor*  
HON. SANDRA D. O'CONNOR

CLERK OF THE COURT  
MAIL DISTRIBUTION CENTER

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ER-559



## Arizona Medical Board

### MD PROFILE PAGE



### Arizona Medical Board

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### General Information

**Lauro Amezcua-Patino MD**

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4055 W. Chandler Blvd., Ste #5  
Chandler AZ 85226  
Phone: (602) 339-3779

License Number: 17900  
License Status: Active  
Licensed Date: 10/07/1988  
License Renewed: 11/05/2020  
Due to Renew By: 11/20/2022  
If not Renewed, License Expires: 03/20/2023

### Education and Training

Medical School: Universidad Autónoma de Baja California Facultad de Medicina Mexicali  
Mexicali, Baja California  
Mexico

Graduation Date: 04/29/1983

Residency: 06/01/1985 - 06/30/1989 (Psychiatry)  
MARICOPA MEDICAL CENTER ACGME Approved  
PHOENIX, AZ

Area of Interest Psychiatry  
Area of Interest Sleep Medicine

The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at <http://www.abms.org> to determine if the physician has earned a specialty certification from this private agency.

### Board Actions

None

A person may obtain additional public records related to any licensee, including dismissed complaints and non-disciplinary actions and orders, by making a written request to the Board. The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

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Board actions taken against physicians in the past 24 months are also available in a [chronological list](#).

Credentials Verification professionals, please [click here](#) for information on use of this website.

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nia; brief psychotic disorder; delusional disorder; other specified or unspecified schizophrenia spectrum and other psychotic disorder; schizotypal, schizoid, or paranoid personality disorders; autism spectrum disorder; disorders presenting in childhood with disorganized speech; attention-deficit/hyperactivity disorder; obsessive-compulsive disorder; posttraumatic stress disorder; and traumatic brain injury.

Since the diagnostic criteria for schizophreniform disorder and schizophrenia differ primarily in duration of illness, the discussion of the differential diagnosis of schizophrenia also applies to schizophreniform disorder.

**Brief psychotic disorder.** Schizophreniform disorder differs in duration from brief psychotic disorder, which has a duration of less than 1 month.

# Schizophrenia

Diagnostic Criteria	295.90 (F20.9)
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- A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
  - 1. Delusions.
  - 2. Hallucinations.
  - 3. Disorganized speech (e.g., frequent derailment or incoherence).
  - 4. Grossly disorganized or catatonic behavior.
  - 5. Negative symptoms (i.e., diminished emotional expression or avolition).
- B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).
- C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

**Specify if:**

The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

**First episode, currently in acute episode:** First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An *acute episode* is a time period in which the symptom criteria are fulfilled.

**First episode, currently in partial remission:** *Partial remission* is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

**First episode, currently in full remission:** *Full remission* is a period of time after a previous episode during which no disorder-specific symptoms are present.

**Multiple episodes, currently in acute episode:** Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).

**Multiple episodes, currently in partial remission**

**Multiple episodes, currently in full remission**

**Continuous:** Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

**Unspecified**

*Specify if:*

**With catatonia** (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition).

**Coding note:** Use additional code 293.89 (F06.1) catatonia associated with schizophrenia to indicate the presence of the comorbid catatonia.

*Specify current severity:*

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”)

**Note:** Diagnosis of schizophrenia can be made without using this severity specifier.

## Diagnostic Features

The characteristic symptoms of schizophrenia involve a range of cognitive, behavioral, and emotional dysfunctions, but no single symptom is pathognomonic of the disorder. The diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning. Individuals with the disorder will vary substantially on most features, as schizophrenia is a heterogeneous clinical syndrome.

At least two Criterion A symptoms must be present for a significant portion of time during a 1-month period or longer. At least one of these symptoms must be the clear presence of delusions (Criterion A1), hallucinations (Criterion A2), or disorganized speech (Criterion A3). Grossly disorganized or catatonic behavior (Criterion A4) and negative symptoms (Criterion A5) may also be present. In those situations in which the active-phase symptoms remit within a month in response to treatment, Criterion A is still met if the clinician estimates that they would have persisted in the absence of treatment.

Schizophrenia involves impairment in one or more major areas of functioning (Criterion B). If the disturbance begins in childhood or adolescence, the expected level of function is not attained. Comparing the individual with unaffected siblings may be helpful. The dysfunction persists for a substantial period during the course of the disorder and does not appear to be a direct result of any single feature. Avolition (i.e., reduced drive to pursue goal-directed behavior; Criterion A5) is linked to the social dysfunction described under Criterion B. There is also strong evidence for a relationship between cognitive impairment (see the section “Associated Features Supporting Diagnosis” for this disorder) and functional impairment in individuals with schizophrenia.

Some signs of the disturbance must persist for a continuous period of at least 6 months (Criterion C). Prodromal symptoms often precede the active phase, and residual symptoms may follow it, characterized by mild or subthreshold forms of hallucinations or delusions. Individuals may express a variety of unusual or odd beliefs that are not of delusional proportions (e.g., ideas of reference or magical thinking); they may have unusual perceptual experiences (e.g., sensing the presence of an unseen person); their speech may be generally understandable but vague; and their behavior may be unusual but not grossly disorganized (e.g., mumbling in public). Negative symptoms are common in the prodromal and residual phases and can be severe. Individuals who had been socially active may become withdrawn from previous routines. Such behaviors are often the first sign of a disorder.

Mood symptoms and full mood episodes are common in schizophrenia and may be concurrent with active-phase symptomatology. However, as distinct from a psychotic mood disorder, a schizophrenia diagnosis requires the presence of delusions or hallucinations in the absence of mood episodes. In addition, mood episodes, taken in total, should be present for only a minority of the total duration of the active and residual periods of the illness.

In addition to the five symptom domain areas identified in the diagnostic criteria, the assessment of cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders.

## Associated Features Supporting Diagnosis

Individuals with schizophrenia may display inappropriate affect (e.g., laughing in the absence of an appropriate stimulus); a dysphoric mood that can take the form of depression, anxiety, or anger; a disturbed sleep pattern (e.g., daytime sleeping and nighttime activity); and a lack of interest in eating or food refusal. Depersonalization, derealization, and somatic concerns may occur and sometimes reach delusional proportions. Anxiety and phobias are common. Cognitive deficits in schizophrenia are common and are strongly linked to vocational and functional impairments. These deficits can include decrements in declarative memory, working memory, language function, and other executive functions, as well as slower processing speed. Abnormalities in sensory processing and inhibitory capacity, as well as reductions in attention, are also found. Some individuals with schizophrenia show social cognition deficits, including deficits in the ability to infer the intentions of other people (theory of mind), and may attend to and then interpret irrelevant events or stimuli as meaningful, perhaps leading to the generation of explanatory delusions. These impairments frequently persist during symptomatic remission.

Some individuals with psychosis may lack insight or awareness of their disorder (i.e., anosognosia). This lack of “insight” includes unawareness of symptoms of schizophrenia and may be present throughout the entire course of the illness. Unawareness of illness is typically a symptom of schizophrenia itself rather than a coping strategy. It is comparable to the lack of awareness of neurological deficits following brain damage, termed *anosognosia*. This symptom is the most common predictor of non-adherence to treatment, and it predicts higher relapse rates, increased number of involuntary treatments, poorer psychosocial functioning, aggression, and a poorer course of illness.

Hostility and aggression can be associated with schizophrenia, although spontaneous or random assault is uncommon. Aggression is more frequent for younger males and for individuals with a past history of violence, non-adherence with treatment, substance abuse, and impulsivity. It should be noted that the vast majority of persons with schizophrenia are not aggressive and are more frequently victimized than are individuals in the general population.

Currently, there are no radiological, laboratory, or psychometric tests for the disorder. Differences are evident in multiple brain regions between groups of healthy individuals

and persons with schizophrenia, including evidence from neuroimaging, neuropathological, and neurophysiological studies. Differences are also evident in cellular architecture, white matter connectivity, and gray matter volume in a variety of regions such as the prefrontal and temporal cortices. Reduced overall brain volume has been observed, as well as increased brain volume reduction with age. Brain volume reductions with age are more pronounced in individuals with schizophrenia than in healthy individuals. Finally, individuals with schizophrenia appear to differ from individuals without the disorder in eye-tracking and electrophysiological indices.

Neurological soft signs common in individuals with schizophrenia include impairments in motor coordination, sensory integration, and motor sequencing of complex movements; left-right confusion; and disinhibition of associated movements. In addition, minor physical anomalies of the face and limbs may occur.

## Prevalence

The lifetime prevalence of schizophrenia appears to be approximately 0.3%–0.7%, although there is reported variation by race/ethnicity, across countries, and by geographic origin for immigrants and children of immigrants. The sex ratio differs across samples and populations: for example, an emphasis on negative symptoms and longer duration of disorder (associated with poorer outcome) shows higher incidence rates for males, whereas definitions allowing for the inclusion of more mood symptoms and brief presentations (associated with better outcome) show equivalent risks for both sexes.

## Development and Course

The psychotic features of schizophrenia typically emerge between the late teens and the mid-30s; onset prior to adolescence is rare. The peak age at onset for the first psychotic episode is in the early- to mid-20s for males and in the late-20s for females. The onset may be abrupt or insidious, but the majority of individuals manifest a slow and gradual development of a variety of clinically significant signs and symptoms. Half of these individuals complain of depressive symptoms. Earlier age at onset has traditionally been seen as a predictor of worse prognosis. However, the effect of age at onset is likely related to gender, with males having worse premorbid adjustment, lower educational achievement, more prominent negative symptoms and cognitive impairment, and in general a worse outcome. Impaired cognition is common, and alterations in cognition are present during development and precede the emergence of psychosis, taking the form of stable cognitive impairments during adulthood. Cognitive impairments may persist when other symptoms are in remission and contribute to the disability of the disease.

The predictors of course and outcome are largely unexplained, and course and outcome may not be reliably predicted. The course appears to be favorable in about 20% of those with schizophrenia, and a small number of individuals are reported to recover completely. However, most individuals with schizophrenia still require formal or informal daily living supports, and many remain chronically ill, with exacerbations and remissions of active symptoms, while others have a course of progressive deterioration.

Psychotic symptoms tend to diminish over the life course, perhaps in association with normal age-related declines in dopamine activity. Negative symptoms are more closely related to prognosis than are positive symptoms and tend to be the most persistent. Furthermore, cognitive deficits associated with the illness may not improve over the course of the illness.

The essential features of schizophrenia are the same in childhood, but it is more difficult to make the diagnosis. In children, delusions and hallucinations may be less elaborate than in adults, and visual hallucinations are more common and should be distinguished from normal fantasy play. Disorganized speech occurs in many disorders with childhood onset (e.g., autism spectrum disorder), as does disorganized behavior (e.g., attention-deficit/

hyperactivity disorder). These symptoms should not be attributed to schizophrenia without due consideration of the more common disorders of childhood. Childhood-onset cases tend to resemble poor-outcome adult cases, with gradual onset and prominent negative symptoms. Children who later receive the diagnosis of schizophrenia are more likely to have experienced nonspecific emotional-behavioral disturbances and psychopathology, intellectual and language alterations, and subtle motor delays.

Late-onset cases (i.e., onset after age 40 years) are overrepresented by females, who may have married. Often, the course is characterized by a predominance of psychotic symptoms with preservation of affect and social functioning. Such late-onset cases can still meet the diagnostic criteria for schizophrenia, but it is not yet clear whether this is the same condition as schizophrenia diagnosed prior to mid-life (e.g., prior to age 55 years).

## Risk and Prognostic Factors

**Environmental.** Season of birth has been linked to the incidence of schizophrenia, including late winter/early spring in some locations and summer for the deficit form of the disease. The incidence of schizophrenia and related disorders is higher for children growing up in an urban environment and for some minority ethnic groups.

**Genetic and physiological.** There is a strong contribution for genetic factors in determining risk for schizophrenia, although most individuals who have been diagnosed with schizophrenia have no family history of psychosis. Liability is conferred by a spectrum of risk alleles, common and rare, with each allele contributing only a small fraction to the total population variance. The risk alleles identified to date are also associated with other mental disorders, including bipolar disorder, depression, and autism spectrum disorder.

Pregnancy and birth complications with hypoxia and greater paternal age are associated with a higher risk of schizophrenia for the developing fetus. In addition, other prenatal and perinatal adversities, including stress, infection, malnutrition, maternal diabetes, and other medical conditions, have been linked with schizophrenia. However, the vast majority of offspring with these risk factors do not develop schizophrenia.

## Culture-Related Diagnostic Issues

Cultural and socioeconomic factors must be considered, particularly when the individual and the clinician do not share the same cultural and socioeconomic background. Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content (e.g., hearing God's voice) are a normal part of religious experience. In addition, the assessment of disorganized speech may be made difficult by linguistic variation in narrative styles across cultures. The assessment of affect requires sensitivity to differences in styles of emotional expression, eye contact, and body language, which vary across cultures. If the assessment is conducted in a language that is different from the individual's primary language, care must be taken to ensure that alogia is not related to linguistic barriers. In certain cultures, distress may take the form of hallucinations or pseudo-hallucinations and overvalued ideas that may present clinically similar to true psychosis but are normative to the patient's subgroup.

## Gender-Related Diagnostic Issues

A number of features distinguish the clinical expression of schizophrenia in females and males. The general incidence of schizophrenia tends to be slightly lower in females, particularly among treated cases. The age at onset is later in females, with a second mid-life peak as described earlier (see the section "Development and Course" for this disorder). Symptoms tend to be more affect-laden among females, and there are more psychotic symptoms, as well as a greater propensity for psychotic symptoms to worsen in later life.

Other symptom differences include less frequent negative symptoms and disorganization. Finally, social functioning tends to remain better preserved in females. There are, however, frequent exceptions to these general caveats.

## Suicide Risk

Approximately 5%–6% of individuals with schizophrenia die by suicide, about 20% attempt suicide on one or more occasions, and many more have significant suicidal ideation. Suicidal behavior is sometimes in response to command hallucinations to harm oneself or others. Suicide risk remains high over the whole lifespan for males and females, although it may be especially high for younger males with comorbid substance use. Other risk factors include having depressive symptoms or feelings of hopelessness and being unemployed, and the risk is higher, also, in the period after a psychotic episode or hospital discharge.

## Functional Consequences of Schizophrenia

Schizophrenia is associated with significant social and occupational dysfunction. Making educational progress and maintaining employment are frequently impaired by avolition or other disorder manifestations, even when the cognitive skills are sufficient for the tasks at hand. Most individuals are employed at a lower level than their parents, and most, particularly men, do not marry or have limited social contacts outside of their family.

## Differential Diagnosis

**Major depressive or bipolar disorder with psychotic or catatonic features.** The distinction between schizophrenia and major depressive or bipolar disorder with psychotic features or with catatonia depends on the temporal relationship between the mood disturbance and the psychosis, and on the severity of the depressive or manic symptoms. If delusions or hallucinations occur exclusively during a major depressive or manic episode, the diagnosis is depressive or bipolar disorder with psychotic features.

**Schizoaffective disorder.** A diagnosis of schizoaffective disorder requires that a major depressive or manic episode occur concurrently with the active-phase symptoms and that the mood symptoms be present for a majority of the total duration of the active periods.

**Schizophreniform disorder and brief psychotic disorder.** These disorders are of shorter duration than schizophrenia as specified in Criterion C, which requires 6 months of symptoms. In schizophreniform disorder, the disturbance is present less than 6 months, and in brief psychotic disorder, symptoms are present at least 1 day but less than 1 month.

**Delusional disorder.** Delusional disorder can be distinguished from schizophrenia by the absence of the other symptoms characteristic of schizophrenia (e.g., delusions, prominent auditory or visual hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms).

**Schizotypal personality disorder.** Schizotypal personality disorder may be distinguished from schizophrenia by subthreshold symptoms that are associated with persistent personality features.

**Obsessive-compulsive disorder and body dysmorphic disorder.** Individuals with obsessive-compulsive disorder and body dysmorphic disorder may present with poor or absent insight, and the preoccupations may reach delusional proportions. But these disorders are distinguished from schizophrenia by their prominent obsessions, compulsions, preoccupations with appearance or body odor, hoarding, or body-focused repetitive behaviors.

**Posttraumatic stress disorder.** Posttraumatic stress disorder may include flashbacks that have a hallucinatory quality, and hypervigilance may reach paranoid proportions. But a trau-

matic event and characteristic symptom features relating to reliving or reacting to the event are required to make the diagnosis.

**Autism spectrum disorder or communication disorders.** These disorders may also have symptoms resembling a psychotic episode but are distinguished by their respective deficits in social interaction with repetitive and restricted behaviors and other cognitive and communication deficits. An individual with autism spectrum disorder or communication disorder must have symptoms that meet full criteria for schizophrenia, with prominent hallucinations or delusions for at least 1 month, in order to be diagnosed with schizophrenia as a comorbid condition.

**Other mental disorders associated with a psychotic episode.** The diagnosis of schizophrenia is made only when the psychotic episode is persistent and not attributable to the physiological effects of a substance or another medical condition. Individuals with a delirium or major or minor neurocognitive disorder may present with psychotic symptoms, but these would have a temporal relationship to the onset of cognitive changes consistent with those disorders. Individuals with substance/medication-induced psychotic disorder may present with symptoms characteristic of Criterion A for schizophrenia, but the substance/medication-induced psychotic disorder can usually be distinguished by the chronological relationship of substance use to the onset and remission of the psychosis in the absence of substance use.

## Comorbidity

Rates of comorbidity with substance-related disorders are high in schizophrenia. Over half of individuals with schizophrenia have tobacco use disorder and smoke cigarettes regularly. Comorbidity with anxiety disorders is increasingly recognized in schizophrenia. Rates of obsessive-compulsive disorder and panic disorder are elevated in individuals with schizophrenia compared with the general population. Schizotypal or paranoid personality disorder may sometimes precede the onset of schizophrenia.

Life expectancy is reduced in individuals with schizophrenia because of associated medical conditions. Weight gain, diabetes, metabolic syndrome, and cardiovascular and pulmonary disease are more common in schizophrenia than in the general population. Poor engagement in health maintenance behaviors (e.g., cancer screening, exercise) increases the risk of chronic disease, but other disorder factors, including medications, lifestyle, cigarette smoking, and diet, may also play a role. A shared vulnerability for psychosis and medical disorders may explain some of the medical comorbidity of schizophrenia.

# Schizoaffective Disorder

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## Diagnostic Criteria

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- A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.
 

**Note:** The major depressive episode must include Criterion A1: Depressed mood.
- B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.
- C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.
- D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

ORIGINAL WAS  
FILED - PINAL COUNTY  
SUPERIOR COURT  
ALMA JENNINGS HAUGHT, CLERK

1 Clarence W. Dixon, 38977  
2 Arizona State Prison  
3 Central Unit  
4 P.O. Box 8200  
5 Florence, AZ 85232

FEB 03 1994

6 In Propria Persona

7 SUPERIOR COURT OF ARIZONA

8 PINAL COUNTY

9 CLARENCE WAYNE DIXON,

10 Prison No. 38977,

11 Petitioner,

12 v.

13 TIM MURPHY,

14 Deputy Warden,

15 Respondent.

No. CV94041734

PETITION FOR WRIT OF

HABEAS CORPUS AND

AFFIDAVIT

JAMES E. DON

16 TO: Pinal County Superior Court

17 Clarence Wayne Dixon petitions for issuance of a writ of  
18 habeas corpus as follows:

19 I.

20 This court has jurisdiction pursuant to A.R.S. § 13-4121 et  
21 seq., Arizona Constitution, Art. 6, § 18; and the United States  
22 Constitution, Art. I § 9.

23 II.

24 Petitioner is currently incarcerated in the Arizona State  
25 Prison, Central Unit, Florence, Arizona, as Prisoner No. 38977,  
26 by the respondent Tim Murphy, who is Deputy Warden.

27 III.

28 Petitioner was taken into custody on June 10, 1985, by a  
Flagstaff City Police Officer in the County of Coconino as a

1 suspect in the sexual assault of a Northern Arizona University  
2 (NAU) student. The same day, petitioner was handed over to NAU  
3 police officers who investigated the assault almost in its  
4 entirety. On December 19, 1985, in Case No. 11654, petitioner  
5 was found guilty by jury trial of Aggravated Assault, A.R.S. §  
6 13-1204(A)(2); Kidnapping, A.R.S. § 13-1304(A)(3); Sexual Abuse,  
7 A.R.S. § 13-1404; and 4 counts of Sexual Assault, A.R.S. § 13-  
8 1406; all dangerous offenses committed while on parole. On  
9 January 6, 1986, petitioner was sentenced to 7 consecutive life  
10 sentences. Petitioner appealed his convictions and sentences all  
11 of which were affirmed in State v. Dixon, 153 Ariz. 151, 735 P.2d  
12 761 (1987).

13 On July 2, 1991, petitioner heard through the news media of  
14 a challenge to the University of Arizona Police Department's  
15 legal authority in a DUI case. On July 31, 1991, petitioner  
16 filed his first post-conviction relief (PCR) petition in the  
17 Coconino County Superior Court.

18 Petitioner's PCR petition was denied at the trial and Court  
19 of Appeals levels. The Supreme Court denied review on August 31,  
20 1993 without opinion or citation to authorities. Petitioner  
21 through Counsel Michael Reddig filed an untimely motion for  
22 reconsideration in the Court of Appeals and petitioner, in fear  
23 of procedural default, filed a pro se supplement to motion for  
24 reconsideration and a petition for writ of habeas corpus in the  
25 state supreme court. The supplement to motion for reconsideration  
26 was denied along with the motion for reconsideration on February  
27 3, 1993. The petition for writ of habeas corpus along with a

1 pro se motion to supplement and consolidate petition for writ of  
2 habeas corpus to 1 CA-CR 92-0171-PR, No. 11654, were dismissed  
3 and denied respectively on April 15, 1993.

4 Petitioner presented his claim challenging legal basis of  
5 the NAU Police Department throughout his PCR proceeding and has  
6 no other petitions, applications or motions pending in any state  
7 or federal court concerning this claim.

8 IV.

9 Petitioner is illegally confined because NAU campus security  
10 officers were without statutory authority to enforce the laws of  
11 the State of Arizona. Their substantial investigation concluding  
12 with the introduction of verbal and physical evidence at  
13 petitioner's trial was in violation of the exclusionary due  
14 process provisions of the federal and state constitutions. This  
15 substantive error deprived the trial court of jurisdiction thus  
16 nullifying petitioner's convictions and sentences.

17 Petitioner further claims ineffective assistance of counsel  
18 at the appellate level in his first Rule 32 PCR proceeding.

19 WHEREFORE, the petitioner asks that the clerk of the court  
20 be ordered to issue a Writ of Habeas Corpus directing the  
21 respondent Tim Murphy, Deputy Warden, to have the body and person  
22 of Clarence Wayne Dixon before this court at a time and place  
23 certain, to show cause why the petitioner should not be released.


24 Respectfully submitted this 30<sup>th</sup> day of January 1994.

25 Clarence W. Dixon

26 Clarence W. Dixon, in pro per.

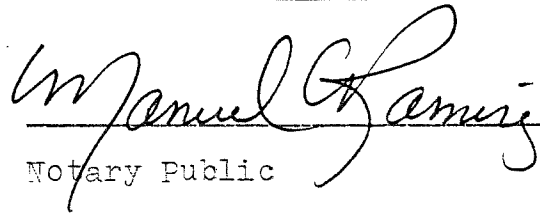
1 STATE OF ARIZONA )  
2 County of Pinal ) ss.

3 Clarence Wayne Dixon, upon being duly sworn, deposes and  
4 says: I am the petitioner in the foregoing petition for writ of  
5 habeas corpus. I am aware of the contents of the petition and  
6 all statements in it are true and correct to the best of my  
7 knowledge, information and belief.

8  
9 

10 Clarence W. Dixon, petitioner.

11 SUBSCRIBED AND SWORN to before me this 30<sup>th</sup> day of January  
12 1994.

13   
14 Notary Public

15 My Commission Expires July 13, 1997

16 My Commission Expires:

17 MEMORANDUM OF AUTHORITIES

18 I.

19 The issue brought by way of this petition for writ of habeas  
20 corpus is whether the NAU Police Department has the statutory  
21 authority to conduct criminal investigations at the time of  
22 petitioner's arrest.

23 Petitioner requests the court take judicial notice of the  
24 following six facts. Ariz. Rules of Evid., Rule 201(b) and (d).

25 1) A.R.S. § 15-1626(A)(2)(Added by Laws 1981, Ch. 1 § 2,  
26 eff. January 23, 1981) was and is statute applicable on or about  
27 June 10, 1985.

2) A.R.S. § 15-1627(Added by Laws 1981, Ch. 1 § 2, eff. January 23, 1981) was and is statute applicable on or about June 10, 1985. See Exhibit A.

3) NAU and its security officers were and are under the jurisdiction of the Arizona Board of Regents.

4) A.R.S. § 1-215(23)(Added by Laws 1981, Ch. 1 § 28, eff. July 25, 1981) was and is statute applicable on or about June 10, 1985. See Exhibit B.

5) Petitioner was arrested June 10, 1985.

6) A.R.S. §§ 1-215(23) and 15-1627 were amended by the 37th Legislature, First Regular Session, Laws 1985, Ch. 280, effective August 7, 1985. See Exhibit D.

On September 5, 1991, by mail, petitioner informed appointed counsel Linda M. Houle that the relevant statutes read quite differently than the statutes as interpreted by the courts in Goode v. Alfred, 171 Ariz. 94, 828 P.2d 1235 (App. 1991). See Exhibit E.

Some of this information was incorporated in petitioner's December 12, 1991 Reply to State's Response and his December 24, 1991 Motion for Rehearing. See Exhibits F and G.

The Honorable Judge Richard K. Mangum in his Minute Entry Order of December 16, 1991, addressing NAU Police Department's authority, stated:

The authority cited by Defendant, a Justice of the Peace Court opinion, has been reversed by the Arizona Court of Appeals; so there was no reason for counsel to raise this issue at trial, as the law was and is against him.

See Exhibit H.

1       The Honorable Judge Mangum completely ignores or fails to  
2 note petitioner's assertion that amended 1981 statute was then  
3 applicable as pointed out in petitioner's Reply to State's  
4 Response wherein Counsel Houle for petitioner stated:

5       A.R.S. § 1-215(23), as amended in 1985, then, clearly defines  
6 University police as peace officers. As it existed at the time  
7 of defendant's arrest, however, A.R.S. § 1-215(23) defined peace  
8 officers as "sheriffs of counties, constables, marshalls,  
9 policemen of cities and towns, and commissioned personnel of the  
10 Department of Public Safety." The version of A.R.S. § 1-215(23)  
11 cited in the Goode case was enacted in June of 1985 and became  
12 effective in August of 1985, after defendant's alleged offense.  
13 Goode is not, therefore, dispositive of the issues raised by  
14 petition.

15       Counsel Houle's reiteration of petitioner's claim in his  
16 Motion for Rehearing was again ignored by the Honorable Judge  
17 Mangum. See Exhibit I.

18       On January 17, 1992, petitioner filed his PCR Petition for  
19 Review from Superior Court. In its December 3, 1992 Memorandum  
20 Decision, the Court of Appeals, Div. One, at page 4, stated:

21       Regarding the NAU Police Department's authority, Dixon  
22 relies upon a now-reversed opinion by a justice of the peace on  
23 the jurisdiction of campus police. This authority is no longer  
24 the law. Goode v. Alfred, 171 Ariz. 94, 828 P.2d 1235 (App.1991).  
25 See Exhibit J.

26       Upholding Judge Mangum's finding, the Court of Appeals also  
27 relied upon Goode v. Alfred, supra, in its determination of the  
28 NAU Police Department's authority.

      The Goode court supported its conclusion that the Board had  
statutory authority to establish a police force "by A.R.S. § 1-  
215(23), which, by amendment in 1985,...". 171 Ariz. at 96, 828  
P.2d at 1237. (Emphasis added.) Historical research of A.R.S. §  
1-215(23) would have confirmed petitioner's contention

1 that amended 1981 A.R.S. § 1-215(23) applied to his case.

2 In failing to adequately investigate fact that there were  
3 changes in the law as asserted by petitioner, and applying the  
4 future law of Goode to his case, both Judge Mangum and the Court  
5 of Appeals abused their judicial functions and duties as to a  
6 question of law. State v. Chapple, 135 Ariz. 281, 297 n.18,  
7 660 P.2d 1208, 1224 n.18 (1983); H.M.L. v. State, 131 Ariz. 385,  
8 387, 641 P.2d 873, 875 (1981).

9 Unless a statute is expressly declared to be retroactive, it  
10 will not govern events that occurred before its effective date.  
11 See A.R.S. § 1-244; State v. Edwards, 136 Ariz. 177, 185, 665  
12 P.2d 59, 67 (1983)(statute in effect at time of the crime is  
13 applicable); State v. LaPonsie, 136 Ariz. 73, 75-76, 664 P.2d  
14 223, 225-26 (App. 1983)(applying A.R.S. § 1-244); Corella v.  
15 Superior Court In & For Pima Cty., 144 Ariz. 418, 420, 698 P.2d  
16 213, 215 (App. 1985)(statute shown not to apply retroactively).  
17 Petitioner can find nothing in the amended 1985 provisions of  
18 A.R.S.- § 15-1627 and § 1-215(23) which indicates an intent by the  
19 legislature to make the amended 1985 statutes retroactive. See  
20 Allen v. Fisher, 118 Ariz. 95, 574 P.2d 1314 (App. 1977).

21 Were NAU police without statutory authority to conduct crim-  
22 inal investigations at time of arrest? Petitioner offers the  
23 following facts and arguments in support of his allegation.

24 1) NAU police officers (R.T. 12/17-18/85, 146, 205, 209)  
25 obtained physical evidence, interviewed witnesses and the victim  
26 (R.T. 12/17/85, 169, 174-75), acquired and executed a court order  
27 and two search warrants (R.T. 12/17-18/85, 169, 179, 182, 209),  
28

1 commanded a crime scene search team (R.T. 12/17/85, 175), one  
2 officer as primary investigator (R.T. 12/17/85, 174), and two  
3 officers testifying at petitioner's trial (R.T. 12/17-18/85, 146,  
4 205). See Exhibit K.

5 2) Nowhere in the applicable A.R.S. § 15-1627 does it state  
6 that campus security officers had authority to enforce the laws  
7 of the State of Arizona. In fact, Paragraph F states:

8 The security officers of each of the institutions shall have  
9 the authority and power of peace officers for the protection of  
10 property under the jurisdiction of the board, the prevention of  
11 trespass, the maintenance of peace and order, only insofar as may  
12 be prescribed by law, and in enforcing the regulations respecting  
13 vehicles upon the property.

14 Paragraph F is a strictly limiting provision concerning the power  
15 and authority of the security officers. Likewise, in the same  
16 section, at Paragraph G, it states:

17 The designation as "peace officers" shall be deemed to be a  
18 peace officer only for the purpose of this section.

19 Both Paragraphs F and G expressly limit the security officers'  
20 scope of authority and no provision is provided for the enforce-  
21 ment of the laws, just regulations respecting vehicles. An  
22 agency, as creature of statute, has only such power and authority  
23 as has been conferred upon it by its organic legislature.

24 Flowing Wells School Dist. v. Vail Sch. Dist., 145 Ariz. 273, 700  
25 P.2d 1378 (App. 1985); Corella v. Superior Court In & For Pima  
26 County, supra; Kendall v. Malcolm, 98 Ariz. 329, 404 P.2d 141  
27 (1965). Without a statute expressly conferring law enforcement  
28 authority and the strictly limiting provisions contained in  
Paragraphs F and G, petitioner contends NAU security officers  
were without the requisite statutory authority to conduct

1 criminal investigations.

2 3) Since A.R.S. § 15-1627(G) limited the security officers'  
3 purposes only to that section, and law enforcement not being one  
4 of the purposes; other statutes could not have been utilized.  
5 E.g., A.R.S. § 13-3911, Search Warrants. Therefore, it follows  
6 that the security officers' execution of a court order and two  
7 search warrants were without legal basis, and physical and verbal  
8 evidence gathered and introduced at petitioner's trial should  
9 have been excluded as fruits of an unlawful search and seizure.  
10 Wong Sun v. United States, 371 U.S. 471, 83 S.Ct. 407, 9 L.Ed.2d  
11 441 (1963); and its progeny. Cf, Brewer v. State, 286 Ark. 1,  
12 688 S.W.2d 736 (1985). See Exhibit L. Provisions of U.S.C.A.  
13 Const.Amend. 4 (Search & Seizure) are applicable to states  
14 through due process clause of U.S.C.A. 14. State v. Tellez, 6  
15 Ariz.App. 251, 431 P.2d 691 (1967). By acting outside statutory  
16 authority, the NAU Police Department deprived petitioner of his  
17 liberty and property in violation of his substantive due process  
18 rights guaranteed him by the 14th Amendment, United States Const.,  
19 and the Arizona Const., Art. 2, § 4.

20 4) At the time of petitioner's arrest, NAU police were not  
21 included in the provisions of A.R.S. § 1-215(23). See Exhibit B.

22 5) Petitioner contends the 1981 State legislature had no  
23 intent to confer full peace officer status upon NAU security  
24 officers since A.R.S. § 1-215(23) was amended to add: "and  
25 commissioned officers of the department of public safety.", some  
26 seven months after amended changes to § 15-1627, when inclusion  
27 of the security officers would have been most appropriate. In  
28

1 determining legislative intent, court may examine both prior and  
2 subsequent statutes 'in pari materia'. Isley v. School District,  
3 81 Ariz. 280, 305 P.2d 432 (1956). That the State legislature  
4 did not include campus security officers within § 1-215(23)  
5 provides further substantiation that these officers were without  
6 full peace officer status and, thus, the requisite authority to  
7 conduct criminal investigations.

8 6) The Court of Appeals' Memorandum Decision (Exhibit J)  
9 labeled the NAU Police Department's authority as "jurisdiction"  
10 (page 2) and as "the jurisdiction of campus police" (page 4).  
11 Considered in this context, "A court's jurisdiction at the  
12 beginning of trial may be lost 'in the course of the proceedings'  
13 due to a failure to complete the court...". Johnson v. Zerbst,  
14 304 U.S. 458, 468, 58 S.Ct. 1019 (1938)(6th Amendment violation).  
15 If the NAU security officers lacked proper authority, then a 14th  
16 Amendment violation occurred and the trial court subsequently  
17 loss its jurisdiction. A.R.S. § 13-4132(1),(3); State v. Montez,  
18 102 Ariz. 444, 432 P.2d 456 (1967). Jurisdiction is derivative,  
19 Anonymous Wife v. Anonymous Husband, 153 Ariz. 570, 739 P.2d 791  
20 (1986); Webb v. Charles, 125 Ariz. 558, 611 P.2d 562 (1980); In  
21 re Estate of Alfaro, 18 Ariz.App. 173, 500 P.2d 1161 (1972); and  
22 Piley v. County of Cochise, 10 Ariz.App. 55, 455 P.2d 1005 (1969).

23 Application of law shows petitioner's claim to be meritor-  
24 ous, yet petitioner believes the trial and appellate courts  
25 refused and ignored applying relevant law because of the horrend-  
26 ous nature of sexual assault, the possibility of petitioner's

1 release, the State's embarrassment that for many years a law  
2 enforcement entity has operated without statutory authority, and  
3 the further harm caused to the victim if petitioner is retried.

4 Because of the substantial contributions of the NAU Police  
5 Department to petitioner's trial, a challenge to its statutory  
6 authority is a challenge to the trial court's jurisdiction.

7 Issues of jurisdiction can be brought at any time. Mammo v.  
8 State, 138 Ariz. 528, 530, 675 P.2d 1347, 1349 (App. 1983);  
9 Hughes Aircraft Co. v. Industrial Commission, 125 Ariz. 1, 606  
10 P.2d 819 (1979); Dassinger v. Oden, 124 Ariz. 551, 606 P.2d 41  
11 (App. 1979); and Board of Sup'rs of Maricopa Cty. v. Woodall, 120  
12 Ariz. 391, 586 P.2d 640 (App. 1978), vacated on other grounds,  
13 120 Ariz. 379, 586 P.2d 628 (1978).

14 The writ of habeas corpus is the appropriate forum to review  
15 matters affecting court's jurisdiction, Powell v. State, 19 Ariz.  
16 App. 377, 507 P.2d 989 (1973); State v. Court of Appeals, Div.  
17 Two, 101 Ariz. 166, 416 P.2d 599 (1966); and State ex rel. Jones  
18 v. Superior Court In & For Pinal County, 78 Ariz. 392, 280 P.2d  
19 691 (1955), and may be used to collaterally attack judgments of  
20 conviction involving loss of jurisdiction because of a denial of  
21 federal and state constitutional rights. H.M.L. v. State, 131  
22 Ariz. 385, 641 P.2d 873 (App. 1981); State v. Montez, supra, and  
23 Applications of Oppenheimer, 95 Ariz. 292, 389 P.2d 696, cert.  
24 denied 84 S.Ct. 1359, 377 U.S. 948, 12 L.Ed.2d 311 (1964).  
25 Petitioner believes his petition for writ of habeas corpus meets  
26 these standards for review.

## II

The issue brought by way of this petition for writ of habeas corpus is whether appointed appellate counsel Michael Reddig was ineffective in his assistance to petitioner.

On January 20, 1992, Michael Reddig (Reddig) was appointed as counsel for petitioner. See Exhibit M. On or about March 11, 1992, Reddig sent a letter to petitioner. See Exhibit N. On December 3, 1992, the Court of Appeals rendered its Memorandum Decision (Exh. J), a copy of which was sent to petitioner by Reddig without an explanatory cover letter. Petitioner provides the court with the envelope postmarked December 8, 1992. See Exhibit O. Reddig answered petitioner's four December 1992 letters with his January 6, 1993 letter and copy of motion for reconsideration. See Exhibits P and Q.

Petitioner must prove ineffective assistance of counsel by establishing that counsel's performance fell below an objective standard of reasonableness, and petitioner must also establish that counsel's deficient performance prejudiced the outcome of the case. Strickland v. Washington, 446 U.S. 684, 104 S.Ct. 2054, 80 L.Ed.2d 674 (1984); State v. Nash, 143 Ariz. 392, 694 P.2d 222 (1985); and State v. Watson, 134 Ariz. 1, 653 P.2d 351 (1982). Standard of ineffectiveness is same for trial and appellate counsel. Mattire v. Wainwright, 811 F.2d 1430 (11th Cir.) cert. denied 479 U.S. 994, 107 S.Ct. 597, 93 L.Ed.2d 597 (1986). Standards of Strickland, supra, also apply to appeals. Evitts v. Lucey, 469 U.S. 387, 105 S.Ct. 830, 83 L.Ed.2d 821 (1985).

In Reddig's March 11th letter, he states "we will file a

1 petition for reconsideration and review in the Supreme Court in  
2 accordance with Rule 32.9(f)." (Now 32.9(g)). See Exhibit N.  
3 Reddig never filed a petition for review by the supreme court.  
4 See Exhibits R and S. Appointed counsel has no duty to petition  
5 the supreme court in some other proceeding beyond the conclusion  
6 of the original appeal. However, when the court of appeals'  
7 decision has been rendered, the attorney should advise the  
8 defendant about his legal rights but the attorney has no oblig-  
9 ation to seek further relief through the appellate process.  
10 State v. Shuttuck, 140 Ariz. 582, 585, 684 P.2d 154, 157 (1984).

11 Petitioner alleges Reddig created an obligation to petition  
12 the Supreme Court or in the least, was duty bound to timely  
13 inform petitioner of his intent not to petition for review in the  
14 Supreme Court. In State v. Shattuck, supra, the court states  
15 that petitioner may petition for review pro per. Id., 140 Ariz.  
16 at 585, 684 P.2d at 157. How can petitioner proceed in pro per  
17 when counsel fails his professional obligation to timely inform  
18 petitioner that counsel would not seek review?

19 Petitioner has an "absolute right to counsel" in a first PCR  
20 petition, State v. Sandon, 161 Ariz. 157, 158, 777 P.2d 220, 221  
21 (1989), and although petitioner has no "right to appeal" to the  
22 Supreme Court, review being discretionary, Jennison v. Goldsmith,  
23 940 F.2d 1308 (9th Cir. 1991), petitioner was assured review to  
24 the Supreme Court by Reddig through his March 11th letter.  
25 Reddig advised petitioner to proceed to the federal courts in a  
26 habeas corpus petition. See Exhibit P. Whether the high state  
27 court accepts review is discretionary but presentation is a  
28

1 prerequisite before the federal courts will accept habeas corpus  
2 review. Jennison v. Goldsmith, supra; 28 U.S.C.A. § 2254(b).  
3 Petitioner cannot assert a claim of ineffectiveness of appellate  
4 counsel to the state supreme court without first presenting his  
5 claim to some other lower state court. State v. Brewer, 170  
6 Ariz. 486, 498-99, 826 P.2d 783, 795-96 (1992)(citations omitted).

7 Petitioner informs the court Reddig's implied statement in  
8 his January 6th letter (Exh. P) that a petition for review had  
9 been denied is without factual basis. See Exhibits R and S.

10 Reliance on Reddig's stated intent to proceed to the supreme  
11 court, and his failure therein, violated his duty to competently  
12 represent petitioner contrary to Supreme Court Rule 42, ER 1.1;  
13 Matter of Nelson, 170 Ariz. 345, 824 P.2d 741 (1992); United  
14 States Const.Amend. 6; and Art. 2, § 4, Arizona Constitution.

15 After the Honorable Judge Rudolph Gerber denied the motion  
16 for reconsideration, petitioner submitted three motions for an  
17 extension of time. See Exhibits T, U, V and W. Petitioner  
18 includes the Supreme Court order of April 15, 1993 dismissing his  
19 pro se petition for writ of habeas corpus and denying his pro se  
20 motion to supplement and consolidate. See Exhibit X. Finally,  
21 petitioner includes the Supreme Court order denying his untimely  
22 pro se petition for review by the Supreme Court, PCR, on August  
23 31, 1993. See Exhibit V.

24 A petition for habeas corpus relief was summarily denied  
25 where its contents showed that the petitioner was relying upon  
26 repetitious matters asserted in previous unsuccessful petitions  
27 and where the grounds urged did not justify the interposition of

1 the writ. Applications of Oppenheimer, supra. The grounds urged  
2 in this petition are identical to that asserted in his first  
3 Rule 32 PCR petition, however, there is justification for the  
4 interposition of the writ of habeas corpus because such ground  
5 was not adjudicated on its merits in the Rule 32 courts. Further,  
6 the Court of Appeals, Division Two, stated: "It is well-settled  
7 that in a habeas corpus proceeding a court will not pass on  
8 matters of defense." Powell v. State, supra, (citations omitted).

9       Petitioner has not burdened the courts with frivolous and  
10 repetitious applications, motions or petitions. See State v.  
11 McFord, 132 Ariz. 132, 644 P.2d 286 (App. 1982)(seventh Rule 32  
12 petition dismissed). Petitioner filed his first Rule 32 petition  
13 in July 1991, after discovery of a valid challenge and defense to  
14 his confinement, an interval of four plus years from the high  
15 state court's decision in State v. Dixon, 153 Ariz. 151, 735 P.2d  
16 761 (1987).

17       Petitioner finally requests the court accept this pro se  
18 petition for writ of habeas corpus, its accompanying memorandum  
19 of authorities with exhibits, and his affidavit in forma pauperis  
20 with tolerance and liberality. Application of Buccheri, 6 Ariz.  
21 App. 196, 431 P.2d 91 (1967).

22 //

Honorable T. G. Nelson  
United States Ninth Circuit  
Court of Appeals  
P.O. Box 193939  
San Francisco, CA 94119-3939

OFFICE OF THE CLERK  
U.S. COURT OF APPEALS  
9TH CIRCUIT  
FILED  
11-10-97  
DOCKETED  
DATE  
INITIAL

Re: No. 97-16849, DC# CV-97-0250-EHC Arizona (Phoenix)

Dear Honorable Judge Nelson:

On November 3, 1997, I received your Order denying me a Certificate of Appealability pursuant to 28 U.S.C. § 2253(c)(2). I respectfully request and pray you reconsider the denial of the certificate of appealability for the following reasons.

On June 10, 1985, I was arrested and charged with multiple felony counts involving the sexual assault of a Northern Arizona University coed. In December 1985, by jury trial, I was convicted on numerous counts including sexual assault and kidnapping. The crime was thoroughly investigated by N.A.U. police officers who gathered evidence and testified at my trial.

On July 31, 1991, I filed a post-conviction relief petition raising the claim that the N.A.U. police officers did not have law enforcement authority. Subsequently, the trial judge, Hon. Richard K. Mangum, retired, ruled Goode v. Alfred, 171 Ariz. 94 (App. 1991) applied and denied my claim. Throughout the ensuing years, state trial, appellate and supreme court judges have ruled that Goode v. Alfred, supra, applied. The Hon. Earl H. Carroll, U.S. District Court Judge, followed the Magistrate's Report and Recommendation denying my petition for writ of habeas corpus.

The one claim I have consistently brought before the state courts and the federal court is the lack of jurisdiction of the university police. Goode v. Alfred, supra, interpreted state statutes after August 7, 1985. The university police at the time of my arrest were operating under the authority of statutes effective before August 7, 1985, and no state court or the federal district court would interpret these statutes.

These applicable statutes did not include the university police in definitions of who is a Peace Officer and severely limited the officers in their duties and authority. See A.R.S. § 1-215 (23)(1981) and A.R.S. § 15-1627(1981).

The Writ of Habeas Corpus is not a process to re-determine guilt or innocence but whether the law was correctly applied. The Writ of Habeas Corpus was instituted to protect individuals from being unlawfully prosecuted and imprisoned.

Because the courts would not consider or interpret the pre-August 7, 1985 statutes, and because the courts continuously and erroneously applied Goode v. Alfred when factly Goode v. Alfred did not apply, I firmly believe the courts sought to deny me the constitutional protections of Due Process and Search & Seizure not only because these courts felt me guilty but because to follow and apply the law would have been politically disastrous, a dark embarrassment to the state universities, and unfair to the victim.

A lawful interpretation of the universities' police authority and jurisdiction at the time of my arrest is what I seek. Although this may be a technicality that might grant me a new trial or plea bargain, this technicality is of vital and primal importance to basic tenets of American jurisprudence. The many judges who ruled on my petitions swore an oath of office to uphold the laws of the state, its constitution, and the U.S. Constitution. To allow such a misapplication of law to stand ignores and defies such an oath of office. To allow such a misapplication of law to stand lowers the court and law to mundane and dangerous capriciousness and panders to social and political forces not germane to the rule of law.

Following rules of interpretation of state statutes and a careful reading of guiding Goode v. Alfred clearly indicates there is a huge possibility of university police without a sufficient law enforcement authority and jurisdiction in their major role as police investigators, and I seek the relief that is promised by the Writ of Habeas Corpus.

Additionally, my October 1, 1997 request for assistance of counsel has not been considered.

(I am without the resources of a law library since August 4, 1997 when prison officials removed all Federal Supplements, Federal Reporters, U.S. Supreme Court Reports, Arizona Reports, and the various Digests and Shepard's.)

Respectfully submitted this 5<sup>th</sup> day of November, 1997.

Clarence W. Dixon

Clarence W. Dixon

Prison Number 38977

Arizona State Prison

P.O. Box 8400

Florence, AZ 85232

A True Original and a Copy  
of the foregoing were deposited  
for mailing this 6<sup>th</sup> day of  
November, 1997, to:

Clerk of the Court

U.S. Ninth Circuit Court of

Appeals

P.O. Box 193939

San Francisco, CA 94119-3939

A True Copy of the foregoing  
was deposited for mailing this  
6<sup>th</sup> day of November, 1997, to:

R. Wayne Ford

Assistant Attorney General

1275 W. Washington

Phoenix, AZ 85007-2997

Honorable Judge Thompson  
United States Ninth Circuit  
Court of Appeals  
P.O. Box 193939  
San Francisco, CA 94119-3939

Re: No. 97-16849, DC# CV-97-0250-FHC Arizona (Phoenix)

Dear Honorable Judge Thompson:

On November 3, 1997, I received your Order denying me a Certificate of Appealability pursuant to 28 U.S.C. § 2253(c)(2). I respectfully request you reconsider the denial for the following reasons.

On June 10, 1985, I was arrested and charged with multiple felony counts involving the sexual assault of a Northern Arizona University coed. In December 1985, by jury trial, I was convicted on numerous counts including sexual assault and kidnapping. The crime was thoroughly investigated by N.A.U. police officers who gathered evidence and testified at trial.

On July 31, 1991, I filed a post-conviction relief petition raising the claim that the N.A.U. police officers did not have law enforcement authority. Subsequently, the trial judge, Hon. Richard K. Mangum, retired, ruled Goode v. Alfred, 171 Ariz. 94 (App. 1991) applied and denied my claims. Throughout the ensuing years, state trial, appellate and supreme court judges have ruled that Goode v. Alfred, supra, applied. The Hon. Earl W. Carroll, U.S. District Court Judge, followed the Magistrate's Report and Recommendation denying my petition for writ of habeas corpus.

The one claim I have consistently brought before the state courts and the federal district court is the lack of jurisdiction of the university police. Goode v. Alfred, supra, interpreted state statutes after August 7, 1985. The university police at the time of my arrest were operating under the authority of statutes effective before August 7, 1985, and no state court or the federal district court would interpret these statutes.

These applicable statutes did not include the university police in definitions of who is a Peace Officer and severely limited the officers in their duties and authority. See A.R.S. § 1-215 (23)(1981) and A.R.S. § 15-1627(1981).

The Writ of Habeas Corpus is not a process to redetermine guilt or innocence but whether the law was correctly applied. The Writ of Habeas Corpus was instituted to protect individuals from being unlawfully prosecuted and imprisoned.

Because the courts would not consider or interpret the pre-August 7, 1985 statutes, and because the courts continuously and erroneously applied Goode v. Alfred when factly Goode v. Alfred did not apply, I firmly believe the courts sought to deny me the constitutional protections of Due Process and Search & Seizure not only because these courts felt me guilty but because to follow and apply the law would have been politically disastrous, a dark embarrassment to the state universities, and unfair to the victim.

A lawful interpretation of the universities' police authority and jurisdiction at the time of my arrest is what I seek. Although this may be a technicality that might grant me a new trial or plea bargain, this technicality is of vital and primal importance to basic tenets of American jurisprudence. The many judges who ruled on my petitions swore an oath of office to uphold the laws of the state, its constitution, and the U.S. Constitution. To allow such a misapplication of law to stand ignores and defies such an oath of office. To allow such a misapplication of law to stand lowers the court and law to mundane and dangerous capriciousness and panders to social and political forces not germane to the rule of law.

Following rules of interpretation of state statutes and a careful reading of guiding Goode v. Alfred clearly indicates there is a huge possibility the university police were without sufficient law enforcement authority and jurisdiction in their major role as police investigators, and I seek the relief that is promised by the Writ of Habeas Corpus.

Additionally, my October 1, 1997 request for assistance of counsel has not been considered.

(I am without the resources of a law library since August 4, 1997 when prison officials removed all Federal Supplements, Federal Reporters, U.S. Supreme Court Reports, Arizona Reports, and the various Digests and Shepards'.)

Respectfully submitted this 5<sup>th</sup> day of November, 1997.

Clarence W. Dixon

Clarence W. Dixon

Prison Number 38977

Arizona State Prison

P.O. Box 8400

Florence, AZ 85232

A True Original and a Copy  
of the foregoing were deposited  
for mailing this 6<sup>th</sup> day of  
November, 1997, to:

Clerk of the Court

U.S. Ninth Circuit Court of  
Appeals

P.O. Box 193939

San Francisco, CA 94119-3939

A True Copy of the foregoing  
was deposited for mailing this  
6<sup>th</sup> day of November, 1997, to:

R. Wayne Ford

Assistant Attorney General

1275 W. Washington

Phoenix, AZ 85007-2997

RECEIVED  
U.S. COURT OF  
97 NOV 10 10 17 AM '97  
FILED  
DOCKETED - DATE INITIATED

November 5, 1997

Clerk of the Court  
U.S. Ninth Circuit Court of  
Appeals  
P.O. Box 193939  
San Francisco, CA 94119-3939

Dear Clerk of the Court:

97-16849

Please find enclosed two originals and four copies of two letters to Circuit Judges Thompson and T.G. Nelson. It would be greatly appreciated if you would file the originals, send two copies to the named Judges, and stamp the remaining two copies as either Filed or Received and return them to me in the SASE I have provided for your convenience. These returned copies are for my records.

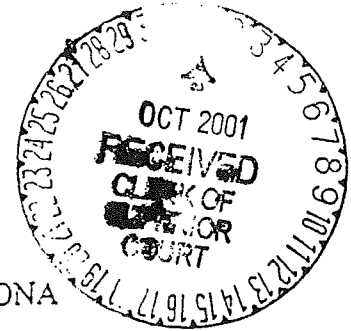
Thank you for your assistance.

Sincerely yours,

*Clarence W. Dixon*

Clarence W. Dixon, 38977  
Arizona State Prison  
P.O. Box 8400  
Florence, AZ 85232

Encl.



IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

COUNTY OF COCONINO

STATE OF ARIZONA, _____	) No. <u>CR- 11654</u>
	)
Plaintiff,	)
	) PETITION FOR POST-
	) CONVICTION RELIEF
	)
v.	)
	)
(INMATE'S NAME) <u>Clarence Wayne Dixon</u>	)
	)
Defendant	)
	)
	)
	)
	)
	)
	)

Instructions: In order for this petition to receive consideration by the court, each applicable question must be answered fully but concisely in legible handwriting or by typing. When necessary, an answer to a particular question may be completed on the reverse side of the page or on an additional blank page, making clear to which question such continued answer refers.

Any false statement of fact made and sworn to under oath in this petition could serve as the basis for prosecution and conviction for perjury. Therefore, exercise care to assure that all answers are true and correct.

A person unable to pay costs of this proceeding and to obtain services of counsel without incurring substantial hardship to himself or his family should complete the Defendant's Financial Statement and Request for Appointed Counsel attached to this petition.

NO ISSUE WHICH HAS ALREADY BEEN RAISED AND DECIDED ON APPEAL OR IN A PREVIOUS PETITION MAY BE USED AS A BASIS FOR THIS PETITION.

TAKE CARE TO INCLUDE EVERY GROUND FOR RELIEF WHICH IS KNOWN AND WHICH HAS NOT BEE RAISED AND DECIDED PREVIOUSLY,

The Ninth Circuit Court of Appeals did not consider nor rule upon Dixon's timely request for appointment of counsel.

Dixon's petition for a writ of certiorari to the United States Court of Appeals for the Ninth Circuit and subsequent motion for rehearing was denied on August 12, 1998 by Justice William K. Suter.

ARGUMENT:

The Defendant was arrested June 10, 1985, the day of the offense. State v. Dixon, 153 Ariz. 151, 735 P.2d 761 (1987). A court challenge to the authority of the University of Arizona police became known to defendant in July 1991. Goode v. Alfred, 171 Ariz. 94, 828 P.2d 1235 (App. 1991).

In 1981, A.R.S. § 1-215(23), which defines who is a Peace Officer, added, "and commissioned personnel of the department of public safety." (Added by Laws 1981 Ch. 1 § 28, effective July 25, 1981).

In 1985, A.R.S. § 1-215(23) was further amended adding, "police officers appointed by the Arizona Board of Regents who have received a certificate from the Arizona Law Enforcement Officer Advisory Council." which became effective August 7, 1985.

In 1981, A.R.S. § 15-1627 granted the Board of Regents the authority to adopt rules similar to the Arizona Motor Vehicle Code; sanctions; and security officers. Included in the 1981 statute were subsections F and G which read as follows:

F. The security officers of each of the institutions shall have the authority and power of peace officers for the protection of property under the jurisdiction of the board, the prevention of trespass, the maintenance of peace and order, only insofar as may be prescribed by law, and in enforcing the regulations

respecting vehicles upon the property.

G. The designation as "peace officer" shall be deemed to be a peace officer only for the purpose of this section.

A.R.S. § 15-1627, F & G, (Added by Laws 1981 Ch. 1 § 2, eff. January 23, 1981).

These pre-August 7, 1985 statutes were made known to Judge Mangum by Ms. Houle in the amended petition for post-conviction relief and the motion for rehearing both filed in late 1991. Judge Mangum did not apply these statutes but cited Goode v. Alfred, supra, to deny the defendant relief.

These substantial statutory changes were made known to Judge Flournoy by defendant in his second post-conviction relief petition and motion for rehearing in mid-1995.

It can be inferred from the circumstances that when Judge Mangum denied the first post-conviction relief petition, he knew 1981 statutes A.R.S. §§ 1-215(23) and 15-1627 applied. It can be inferred from the circumstances that Judge Flournoy likewise knew of the existence and applicability of the 1981 amended statutes.

POINT ONE: A.R.S. § 1-215(23) cited in Goode v. Alfred, supra, includes university police in its definition. A.R.S. § 1-215(23) cited by defendant does not include university police.

POINT TWO: A.R.S. § 15-1627 severely limited the 'security officers' and applied on June 10, 1985 up to August 6, 1985.

So why ignore and disregard defendant's claim? Because to apply and interpret the 1981 statutes would cause the release or re-trial of a convicted felon and more importantly, cause great embarrassment to the Arizona Board of Regents and the fraternity of police statewide. A judge shall not be swayed by partisan interests,

public clamor or fear of criticism. Rule 81, Supreme Court of Arizona, Canon 3(B)(2). Adjudicative Responsibilities. It cannot be said Judge Mangum's and Judge Flournoy's rulings did not contain certain of the elements of Canon 3(B)(2). Their intentionally erroneous applications of Goode may rise to willful misconduct of office. Additionally, Judge Flournoy's knowledge that Judge Mangum knowingly ruled erroneously may have violated Rule 81, Supreme Court of Arizona, Canon 3(D)(1), Disciplinary Responsibilities.

Judge Mangum who ruled on the first PCR petition and did not find (nor expound upon) the facts was not an impartial decisionmaker because his own conduct was at issue. See Rose v. Mitchell, 443 U.S. 545, 563 (1979). Also, in reference to Federal Rule 4(a) of 28 U.S.C.A. § 2255, judges should be cognizant of "motivation to vindicate a prior conclusion when confronted with a question for the second or third time" and that a judge may find it difficult to put aside views formed during some earlier procedures," in which disqualification might be appropriate (quoting David L. Ratner, Disqualification of Judges for Prior Judicial Action, 3 How.L.J. 228, 229-230, 1957).

Defendant claims his federal and state constitutional right to Due Process and the right to a fair and impartial hearing were violated by Judges Richard K. Mangum and J. Michael Flournoy. U.S.C.A. Const.Amend. 14, Arizona Const. Art. 2 § 4., and Ariz. Crim.Rule 32 and Montgomery v. Shelton, 181 Ariz. 256 (1995) opin. supplemented 182 Ariz. 118 (1995)(review for fundamental error mandatory by court).

By knowingly and intentionally citing Goode v. Alfred, supra,

and refusing to interpret the correct 1981 statutes, Judges Mangum and Flournoy abandoned their oaths of office, the Rule of Law, and the integrity of the state judiciary.

Defendant is proceeding pro se and should therefore be produced to manage the presentation of his case, to cross-examine the principals and hear their case and to present rebuttal evidence.

For the above reasons, defendant requests a fair and impartial hearing on the above claim and his initial claim that N.A.U. police lacked authority and jurisdiction to investigate the crime for which defendant stands convicted.

RESPECTFULLY SUBMITTED this 21<sup>st</sup> day of September, 2001.

Clarence W. Dixon

Clarence W. Dixon, 38977

Arizona State Prison

P.O. Box 3300

Florence, AZ 85232

Clarence W. Dixon 38977

P.O. Box 3300

Florence, AZ 85232

SS# 585-84-9186

No Telephone

Word Count - 1870

# CAN & DO THE COURTS COLLUDE?

by

Clarence W. Dixon, c2001

Can state and federal judges conspire to deny a person a lawful right? To collude is to act in collusion or conspire, especially for a fraudulent purpose. Collusion is a secret agreement for fraudulent or illegal purpose; conspiracy. Webster's New World Dictionary, 3rd College Ed., c1994, page 274.

Acts of conspiracy are difficult to prove. Without the testimony of one or more conspirators, only the circumstances and evidence surrounding the acts will weigh and tell. The numerous judicial answers to the appeals and petitions in this particular case will weigh and tell with each reader.

Recognizing and interpreting an amended statute in one criminal case while refusing to recognize the same statute in another case would lead one to believe foul is afoot. In the one case, the appellate court found for the governing Board of Regents that authority exists for the creation of a law enforcement agency. Goode v. Alfred, 171 Ariz. 94, 828 P.2d 1235 (App. 1991). In the other case, the courts misapplied case law to uphold criminal

C. Dixon - 2

convictions and a police force's pre-August 1985 authority and, therefore, its existence.

After a July 1990 arrest, a Tucson motorist challenged the University of Arizona police officer's jurisdiction to stop and arrest off-campus. In his ruling, Pima County Justice of the Peace Robert Donfeld opined that the Board of Regents lacked statutory authority to establish a police department and dismissed several traffic citations and a DUI. State v. Goode, Pima County Justice Court, No. CR 90-008744, June 19, 1991.

The State filed a special action and Pima County Superior Court Judge Michael D. Alfred vacated the dismissal, remanding for further justice court proceedings. Goode v. Alfred, 171 Ariz. 94, 828 P.2d 1235 (App. 1991).

Judge Alfred found for the university and the State. Mr. Goode appealed. The Court of Appeals, Div. Two, held that the Board of Regents had implicit statutory authority to establish a police force concluding that A.R.S. § 15-1626(A)(2) is broad enough to include authorization to establish a police force. The appellate court's conclusion was supported by A.R.S. § 1-215(23) which included within the very definition of a peace officer, "police officers appointed by the Arizona Board of Regents who have received a certificate from the Arizona Law Enforcement Officer Advisory Council." Goode v. Alfred, 171 Ariz. 94, 96, 828 P.2d 1235, 1237 (App. 1991).

In mid-1991, a post-conviction relief (PCR) petition was filed challenging the Northern Arizona University (NAU) Police Department's alleged authority to conduct criminal investigations. The petitioner

C. Dixon - 3

informed public defender Linda M. Houle that an applicable statute read quite differently than one cited in Goode v. Alfred, supra. In petitioner's amended supplement to his PCR petition, Ms. Houle included the claim questioning the legal basis for the existence of the police department. State v. Dixon, Coconino County, Amended Supplement, No. CR-11654, October 18, 1991.

After receiving the county prosecutor's response, Ms. Houle's reply included:

A.R.S. § 1-215(23), as amended in 1985, then, clearly defines University police as peace officers. As it existed at the time of defendant's arrest, however, A.R.S. § 1-215(23) defined peace officers as "sheriffs of counties, constables, marshals, policemen of cities and towns, and commissioned personnel of the department of Public Safety." The version of A.R.S. § 1-215(23) cited in the Goode case was enacted in June of 1985 and became effective in August of 1985, after defendant's alleged offense. Goode is not, therefore, dispositive of the issues raised by petition.

State v. Dixon, Reply, Coconino County, CR-11654, Dec. 12, 1991.

After Coconino County Superior Court Judge Richard K. Mangum, ret., dismissed the PCR, Ms. Houle submitted the required motion for rehearing including the following statement that:

"the court overlooked the fact that Goode v. Alfred, 97 Ariz. Adv.Rep. was based on statutory construction and that the statutes cited had been amended subsequent to petitioner's arrest and conviction. Changes in A.R.S. §1-215(23) and A.R.S. 14-1627\* after petitioner's arrest may well have conferred that ability upon NAU police officers where it did not exist previously."

Dixon, Motion, Coconino County, CR-11654, December 24, 1991.

(14-1627 is a typo and should have read "15-1627")

Before August 7, 1985, A.R.S. § 1-215(23) in its definition of who is a Peace Officer did not include university security officers. A.R.S. § 1-215(23)(Added by Laws 1981 Ch. 1 § 28 eff. July 25, 1981.

C. Dixon - 4

Before August 7, 1985, A.R.S. § 15-1627 granted the Board of Regents the authority to adopt rules similar to the Arizona Motor Vehicle Code; sanctions; and security officer powers. Included in the pre-August 7, 1985 statute are pertinent subsections F and G.

A.R.S. § 15-1627, F & G, 1981, read as follows:

F. The security officers of each of the institutions shall have the authority and power of peace officers for the protection of property under the jurisdiction of the board, the prevention of trespass, the maintenance of peace and order, only insofar as may be prescribed by law, and in enforcing the regulations respecting vehicles upon the property.

G. The designation as "peace officer" shall be deemed to be a peace officer only for the purpose of this section.

A.R.S. § 15-1627, F & G, (Added by Laws 1981 Ch. 1 § 2, eff. Jan. 23, 1981).

Superior Court Judge Mangum denied the July 31, 1991 PCR petition without acknowledging and interpreting the pre-August 7, 1985 statutes. Addressing this specific claim, the court wrote:

"The authority cited by Defendant, a Justice of the Peace Court opinion, has been reversed by the Arizona Court of Appeals; so there was no reason for counsel to raise this issue at trial, as the law was and is against him."

State v. Dixon, Order, CR-11654, Dec. 16, 1991.

The Court of Appeals, Div. One, Rudolph J. Gerber presiding with Ruth V. McGregor and Philip E. Toci participating, granted review and denied relief. In its Dec. 3, 1992 not for publication Memorandum Decision, the appellate court relied upon Goode v. Alfred, supra, to deny the claim stating:

"Regarding the NAU Police Department's authority, Dixon relies upon a now-reversed opinion rendered by a justice of the peace on the jurisdiction of campus police. This authority is no longer the law. Goode v. Alfred, 171 Ariz. 94, 828 P.2d 1235 (App. 1991)."

Ct. of Appeals, Memo Decision, No. CA-CR 92-0171-PR, Dec. 3, 1992.

C. Dixon - 5

After an untimely but accepted filing of a motion for reconsideration, a pro se supplement to motion for reconsideration and a pro se petition for writ of habeas corpus in the Arizona Supreme Court, the court without discussion denied the PCR and habeas corpus petitions by a panel of Chief Justice Feldman, Justice Corcoran, and Justice Zlaket. Dixon, Supreme Court, No. CR-93-0198-PR, August 31, 1993; Dixon v. McFadden, Habeas corpus, Supreme Court, No. HC-93-0006, dismissed, April 15, 1993.

After Dixon brought his first PCR petition through the state courts, he continued with a petition for writ of habeas corpus in Pinal County which was transferred to Coconino County as a second PCR petition denied on August 4, 1995; a petition for review by the supreme court (PCR) denied on December 6, 1996; and a special action petition to the supreme court challenging the transfer of the second habeas corpus petition which was dismissed on July 8, 1994. In all the state proceedings, Dixon raised the claim that NAU police lacked sufficient authority or jurisdiction to conduct criminal investigations.

The United States District Court dismissed without prejudice Dixon's first petition for writ of habeas corpus so unexhausted claims could be pursued in the state courts. Dixon v. Lewis, CIV 95-1852-PCT-EHC (SLV), June 17, 1996.

After state supreme court summary denial of the second PCR petition, Dixon filed his second federal habeas corpus petition. In denying the habeas corpus petition, United States District Court Judge Earl H. Carroll adopted the Report and Recommendation of Magistrate Stephen L. Verkamp which in part read:

C. Dixon - 6

"Federal habeas relief is not available for alleged errors in the interpretation or application of state law. Estelle v. McGuire, 502 U.S. 62, 112 S.Ct. 475, 480, 116 L.Ed.2d 385 (1991); Miller v. Vasquez, 868 F.2d 1116, 1119 (9th Cir. 1989); Middleton v. Cupp, 768 F.2d 1082, 1085 (9th Cir. 1985), cert. denied, 478 U.S. 1021 (1986)."

Dixon v. Steward, Report, CIV 97-250-PHX-EHC (SLV), page 10, July 2, 1997.

In response to the Report, Dixon in part replied:

"As stated in Peltier v. Wright, 15 F.3d 860 (9th Cir. 1994), 'A writ of habeas corpus is available under 28 U.S.C. § 2254(a) only on the basis of some transgression of federal law binding on the state courts. It is unavailable for alleged errors in the interpretation or application of state law. Middleton v. Cupp, 768 F.2d 1083, 1085 (9th Cir. 1985)(citations omitted), cert.denied, 478 U.S. 1021; 106 S.Ct. 3336, 92 L.Ed.2d. 741 (1986). Furthermore, "state courts are the ultimate expositors of state law," and we are bound by the state's construction except when it appears that interpretation is an obvious subterfuge to evade the consideration of a federal issue. Mullaney v. Wilbur, 421 U.S. 684, 691, 95 S.Ct. 1881, 1886, 44 L.Ed.2d 508 (1975). Peltier v. Wright, 15 F.3d 861-62 (9th Cir. 1994)."

Dixon, Reply to Report, CIV 97-250-PHX-EHC (SLV), page 7, July 14, 1997.

In accepting the Report and Recommendation, Judge Carroll ignored a basic tenet of law; that issues of jurisdiction are derivative, Anonymous Wife v. Anonymous Husband, 739 P.2d 791 (Ariz. 1986); that issues of jurisdiction are never waived and can be raised on collateral attack, United State v. Cook, 997 F.2d 1312, 1320 (9th Cir. 1993); that subject matter jurisdiction and court's jurisdiction can be brought for the first time appeal, Mammo v. State, 675 P.2d 1347 (Ariz.App. 1983); and that issues of jurisdiction are reviewed de novo, Kelly v. Michaels, 59 F.3d 1044, 1057 (10th Cir. 1995). The above cases were cited in Dixon's habeas corpus petition.

C. Dixon - 7

A notice of appeal and a motion for issuance of a certificate of probable cause was filed on September 12, 1997. The certificate was denied on September 23, 1997.

In an October 1, 1997 letter, Dixon requested appointment of counsel which was never ruled upon by the United States Court of Appeals for the Ninth Circuit.

On October 27, 1997, a request for issuance of certificate of appealability was denied.

Another letter construed as a motion to reconsider was denied on November 28, 1997.

On February 23, 1998, Dixon submitted his pro se Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit. The petition was denied by United States Supreme Court Justice William K. Suter on May 18, 1998. Dixon's pro se Petition for Rehearing was denied by Justice Suter on August 12, 1998.

From Petitioner's first post-conviction relief petition of July 31, 1991 to the Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit of February 23, 1998, the state and federal courts have refused not to re-interpret statutes but to apply correct statutes in an effective effort to deny relief of a constitutional magnitude. A meritorious claim was raised only to be thwarted by judicial rulings that are more than simple mistakes or oversights but cognizant actions to deny a petitioner guaranteed protection under the Due Process Clause of the Fourteenth Amendment to the United States Constitution and Article 2, Section 4 of the Arizona Constitution.

C. Dixon - 8

Albert Goode received a fair and impartial adjudication of his police jurisdiction claim finally to his disadvantage. Dixon also sought relief under the same but previously amended statutes. But because his claim was definitively to his advantage, he was thwarted by a specious application of state law that did not and still does not apply.

This cumulative, continuous and concerted effort by state and federal judges on its face smacks of collusion and conspiracy or, at the least, complicity and the reader is left considering the circumstantial weight to tell if judicial collusion is found.

XXXX

## COMPLAINT AGAINST A JUDGE

## TO THE COMMISSION ON JUDICIAL CONDUCT:

I allege that Judge J. Michael Flourney of the (check one) ☐ municipal court; ☐ justice court; ☒ superior court; ☐ court of appeals; or ☐ supreme court located in Flagstaff, Arizona, has committed judicial misconduct that involves (check all that apply):

- ☐ The commission of a criminal act.
- ☐ A disability that interferes with the performance of judicial duties.
- ☐ Willful misconduct in office.
- ☐ Willful and persistent failure to perform duties.
- ☐ Habitual intemperance (addiction to alcohol or drugs).
- ☒ Conduct that brings the judicial office into disrepute.
- ☒ A violation of the Arizona Code of Judicial Conduct.

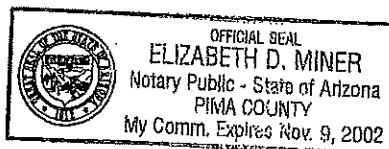
In support of these allegations, I have answered the following questions truthfully and completed the attached statement of facts describing my experience with the judge.

- Did you have a case before this judge? ☒ yes, ☐ no. If yes, what is the case number? CR 85-11654
- What is the name of the case? State of Arizona v. Clarence W. Dixon
- List the names of any attorneys, who appeared in the case: Linda M. Houle, Michael S Reddig, Kaign Christy, Bruce Griffen, John Ellsworth, Wendy F. White, H. Allen Gerhardt, Susan V. Sterman, Michael Hinson, R. Wayne Ford, Jill L. Evans,
- Are you involved in a lawsuit that is still pending before this judge? ☐ yes, ☒ no.
- List your telephone numbers: Daytime: N/A; After hours: N/A
- Street Address: Arizona State Prison-Eyman Complex, Meadows Unit
- City: Florence, State: Arizona Zip Code: 85232
- Print your name: Clarence W. Dixon Today's Date: March 12, 2002
- Clarence W. Dixon

Signature (signed in front of a notary and notarized below)

## VERIFICATION

SUBSCRIBED AND SWORN to before me this 12 day of March, 2002



Elizabeth D. Miner  
Notary Public  
11/9/2002  
My Commission Expires

STATEMENT OF FACTS

NAME: Clarence Dixon JUDGE'S NAME: J. Michael Flournoy DATE: 3/12/02

On June 10, 1985, I was arrested for the sexual assault of a college coed. N.A.U. police investigated obtaining a Court Order and two Search Warrants, gathered evidence, and interviewed witnesses and the victim.

In April 1995, Judge Flournoy was explicitly informed of statutes applicable to my Crim.Rule 32 claim that N.A.U. police lacked jurisdiction at the time of my June 1985 arrest. In August 1995, Judge Flournoy denied my Crim.Rule 32 petition. See attached Petition; pages 1,A-4 & A-5 and Minute Entry Order.

In Sept. 2001, I filed a Crim.Rule 32 petition alleging obstruction by Judge Mangum (ret.) and Judge Flournoy of my right to due process and my right to fair and impartial hearings. Again, I specifically mentioned the 1981 statutes. Initially assigned to Judge Coker, my petition was reassigned to Judge Flournoy who without recusing himself, denied my petition on Feb. 7, 2002. See attached Petition; pages 1,A-4,A-5,A-6 & A-7, and Minute Entry Order.

This is my third Crim.Rule 32 petition and because the superior court judges and appellate state courts will not order a fair and impartial hearing on my due process claim, I seek suspension or censure of Judge J. Michael Flournoy.

////

DIVISION 1  
COURT OF APPEALS  
STATE OF ARIZONA

APR 29 2002

FILED  
GLEN D. CLARK, CLERK  
BY 

1 Clarence W. Dixon, 38977  
2 Arizona State Prison  
3 PO Box 3300  
4 Florence, AZ 85232  
5 In Propria Persona

IN THE

COURT OF APPEALS

STATE OF ARIZONA

DIVISION ONE

1 CACR-02-0203

8 STATE OF ARIZONA, )

9 Plaintiff, )

10 v. )

11 CLARENCE W. DIXON, )

12 Defendant. )

~~1 CA CR 02-0202 PR~~

COCONINO County Superior  
Court, No. CR 85-11654

DEFENDANT'S REPLY TO STATE'S  
RESPONSE TO PETITION FOR  
REVIEW

13 COMES NOW Defendant Clarence W. Dixon, in pro per, and hereby  
14 submits his reply to State's reponse to petition for review, dated  
15 April 9, 2002.

16 The State argues preclusion on issues which were previously  
17 raised, ruled upon and denied in two earliar Rule 32 petitions.

18 The Defendant emphatically asserts his previous Rule 32 court  
19 rulings were rendered debatable because the campus police juris-  
20 diction claim was never finally adjudicated on the merits. Certain  
21 statutes were intentionally and improperly ignored by the trial and  
22 Rule 32 court judges in successful attempts to deny Defendant  
23 certain rights guaranteed by the state and federal constitutions.

24 The Defendant asserts his 3rd Rule 32 petition was improperly  
25 denied by Judge Flournoy who should have recused himself because he  
26 is a named participant in Defendant's claim of obstruction by two

1 superior court judges.

2 Defendant continues to admit and raise his challenge to the  
3 authority of the campus police because his claim is real and sub-  
4 stantial and his denied rights to fair and impartial hearings and  
5 due process are real and substantial.

6 Because the trial and Rule 32 court judges actively sought to  
7 misapply the law and the authority of campus police was and is  
8 challenged, the courts' jurisdiction became and is an issue. And  
9 as stated in previous submissions; issues of a court's jurisdiction  
10 are never waived and can be raised at any time.

11 The State asserts Defendant 'cites no law for his position' on  
12 Defendant's challenge to the authority of the judges. The State  
13 ignores Defendant's citation of Rule 81, Code of Judicial Conduct,  
14 Supreme Court of Arizona. Additionally, when the Ninth Circuit  
15 Court of Appeals allowed the Dept. of Corrections to remove law  
16 libraries from Arizona's prisons in August 1997 (except Central  
17 Unit), Defendant's meaningful and real ability to access and re-  
18 search the law was and is seriously prejudiced.

19 Defendant's claims are further bolstered by the cumulative  
20 efforts of the State and Rule 32 court judge to intentionally set  
21 aside principles of judicial recusal and principles of statutory  
22 application and interpretation.

23 RESPECTFULLY SUBMITTED this 24<sup>th</sup> day of April, 2002.

24 Clarence W. Dixon

25 Clarence W. Dixon, in pro per

June 12, 2002

E. Keith Stott, Jr.  
Executive Director  
Commission on Judicial Conduct  
1501 W. Washington, Suite 229  
Phoenix, AZ 85007

Re: Case No. 02-068

Dear Mr. Stott:

Thank you for your June 6 letter.

On bad faith, in your February 21 letter, you wrote that, "bad faith implies that a judge was fully aware of his duty under the law at the time of his ruling and then willfully ruled contrary for reasons of his own." This is exactly the circumstances under which Judge Flournoy (and several others) acted.

There is no discretion but a duty to apply the law fairly and correctly.

I have sought a true and correct application of the law for eleven years now. Mine is a unique and exceptional claim and I firmly believe all Commission members need to know of this very valid challenge to police authority and the judicial bad faith involved. Beyond the possibility of my freedom lies the very real damage to the judiciary and the Rule of Law bad faith acts engender; a damage I believe the Commission on Judicial Conduct was created to combat through vigilance and proper sanctions.

My complaint against Judge Flournoy is real and an integral part of the Arizona justice system and because my police authority claim is rare and a political firebomb, the public needs to be represented by the Commission on Judicial Conduct.

I await the decision of the Commission's review meeting of July 19. Thank you for your time and considerations. I am ...

Sincerely,



Clarence Dixon, #38977  
Arizona State Prison  
P.O. Box 3300  
Florence, AZ 85232

cc:cd

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA  
IN AND FOR THE COUNTY OF MARICOPA

STATE OF ARIZONA,  
Plaintiff,

v.

CLARENCE DIXON,  
Defendant.

No. CR 02-19595

MOTION TO SUPPRESS DNA  
EVIDENCE  
(Evidentiary Hearing/ Oral  
Argument Requested)

COMES NOW the Defendant, by and through his undersigned attorney, and hereby moves this court to suppress all DNA evidence prior, arising and subsequent to the indictment of the Defendant on November 26, 2002. This motion is based upon the Memorandum of Points and Authorities attached hereto and made a part hereof by this reference.

DATED the \_\_\_\_\_ day of May, 2003.

W. Vikki M. Liles

Attorney for Defendant

MEMORANDUM OF POINTS AND AUTHORITIES

I. FACTS:

On or about the middle of 1995 (or 1996?) Defendant Dixon (Dixon) was ordered to surrender his blood and saliva samples by Arizona Department of Corrections medical personnel in accordance with A.P.S. § \_\_\_\_\_ for the purpose of his inclusion in a state and national DNA data base for crime comparison analysis.

On or about \_\_\_\_\_ DNA analysis indicated Dixon's semen/blood/saliva was present on the bedspread/panties/vagina swab taken from the crime scene/body of Deana Lynn

II

Bowdoin, murdered on January 7, 1978 in Tempe, Arizona.

On June 10, 1985, Dixon was arrested for the sexual assault of a N.A.U. coed, N.A.U. police, in the week following, investigated gathering evidence, interviewing witnesses and the victim, obtained two search warrants and one court order, and testified at Dixon's December 1985 trial. Dixon was found guilty by jury and on January 6, 1986 sentenced to seven consecutive life sentences. State v. Dixon, 153 Ariz. 157, 735 P.2d 761 (1987).

On July 31, 1991, Dixon filed his first Crim. Rule 32 petition after hearing of a DUI suspect's challenge to University of Arizona police authority. The Honorable Robert Donfeld, Justice Court, found the university police lacking statutory authority and the State appealed. The Pima County Superior Court reversed and the defendant sought special action. In Greale v. Alfred, 171 Ariz. 94, 828 P.2d 1235 (App. 1991), the appellate court found that statutes 'amended' in 1985 did grant the state Board of Regents authority to establish and maintain a police force. Greale v. Alfred, 171 Ariz. 94, 96, 828 P.2d 1235, 1237.

The Honorable Richard K. Mangum, retired, ruled that Greale v. Alfred, supra, applied to Dixon's claim that N.A.U. police lacked statutory authority to investigate the crime he stood convicted of although Public Defender Linda M. Houle informed the court of the applicability of statutes effective in 1981. Ms. Houle filed a timely motion for rehearing which was denied on January 13, 1992. Coconino County Superior Court No. CR 85-11654. Dixon's petition for review from superior court was denied relief by Judge Gerber,

## III

McGregor and Toci on December 3, 1992. Court of Appeals, Div. One, CA-CR 92-0171 PR. Dixon's petition for review by the supreme court was denied without comment or discussion on August 31, 1993 by Justices Feldman, Coreman and Zlaket, Arizona Supreme Court No. CR 93-0195 PR. Dixon continued in the state courts with a habeas corpus petition in the supreme court dismissed April 15, 1993 by Justice Zlaket. Arizona Supreme Court No. MC 93-0006; a habeas corpus petition in Pinal County transferred to Coconino County as a 2<sup>nd</sup> Crim. Rule 32 petition denied on August 4, 1995 by Judge Flournoy, No. CR 85-11654; a petition for review from Superior Court denied on July 11, 1996 by Judges Graber, Lambford and Sult, Court of Appeals, Div. I, CA-CR 95-0831 PR; a petition for review by supreme court denied on December 9, 1996 by Justices Feldman, Zlaket and Jones, Arizona Supreme Court No. CR 96-0447 PR; a special action petition was dismissed by the supreme court on July 8, 1994 by Justice Moeller, Arizona Supreme Court No. M-94-0014, Pinal County No. CV 94-041734; a 2<sup>nd</sup> Crim. Rule 32 petition denied by Judge Flournoy on February 4, 2003, No. CR 85-11654; a petition for review from superior court denied on \_\_\_\_\_ by Judges \_\_\_\_\_ and \_\_\_\_\_, Court of Appeals, Div. One, No. CA-CR 02-0203 PR; and a petition for review in the supreme court denied on April 17, 2003 by Justices Bevel, Ryan and Hurwitz, Arizona Supreme Court No. CR 03-0076 PR.

In all Dixon's petitions, he has brought forth the claim that N.A.U. police lacked sufficient statutory authority or jurisdiction to conduct criminal felony investigations on June 10, 1985 and up to

IV

August 6, 1985.

## II. LAW AND ARGUMENT:

Defendant Dixon's 1985-86 convictions and sentences in State v. Dixon, 153 Ariz 151, 735 P.2d 761 (1987) were unlawfully obtained because N.A.U. police under color of state law were, at the time of the offense and Dixon's arrest, without statutory authority, implied or explicit. See A.R.S. § 15-1627 (1981), particularly Paragraphs F and G. The use of unlawfully obtained evidence at trial is impermissible and fundamental error through the doctrine of the Exclusionary Rule. Wong Sun v. United States, 33 S.Ct. 407, 371 U.S. 407 (1963) \*APPROPRIATE ARIZONA CITATION\* And because the State is now using DNA comparison evidence obtained from Dixon in mid-1985 (or mid-1986) while illegally incarcerated, it too must be suppressed as "fruit of the poisonous tree" simply because it would not have come to light but for the illegal actions of the police." Wong Sun v. United States, 33 S.Ct. 407 417, 371 U.S. 407, 488, Ariz.

Dixon was arrested on June 10, 1985, the day of the offense. State v. Dixon 153 Ariz. 151, 735 P.2d 761 (1987). A DUI suspect's challenge to the authority of the University of Arizona police became known to Dixon and he filed his First Crim. Rule 32 petition on July 31, 1991. Coconino County Superior Court No. CR 85-11654.

In 1981, A.R.S. § 1-215(23), which defines who is a Peace Officer, added "and commissioned personnel of the department of public safety." (Added by Laws 1981 Ch. 1 § 28, effective July 28, 1981).

In 1985, A.R.S. § 1-215(23) was amended adding, "police officers appointed by the Arizona Board of Regents who have received a

V

certificate from the Arizona Law Enforcement Officer Advisory Council," which became effective August 7, 1985.

In 1981, A.R.S. 15-1627 granted the Board of Regents the authority to adopt rules similar to the Arizona Motor Vehicle Code; sanctions; and security officers. Included in the 1981 statute were subsections F and G which read as follows:

F. The security officers of each of the institutions shall have the authority and power of peace officers for the protection of property under the jurisdiction of the board, the prevention of trespass, the maintenance of peace and order, only insofar as may be proscribed by law, and in enforcing the regulations respecting vehicles upon the property.

G. The designation as "peace officer" shall be deemed to be a peace officer only for the purpose of this section.

A.R.S. § 15-1627 (1981) (Added by Laws 1981 Ch. 1 § 2, effective January 23, 1981).

These pre-August 7, 1985 statutes were made known to Judge Mangum by Public Defender Houde in the amended petition for post-conviction relief and motion for rehearing filed in late 1991. Judge Mangum did not apply these statutes but cited Quale v. Alford, *supra*, to deny Dixon relief.

These substantial statutory changes were made known to all the state courts reviewing Dixon's petitions from 1991 to the present.

It can be inferred from the circumstances that when Judge Mangum denied Dixon's first Crim. Rule 32 petition, he knew 1981 A.R.S. § 1-215(23) and A.R.S. § 15-1627 applied. It can be inferred from the circumstances

## VI

that all the other appellate courts likewise knew of the existence and applicability of the amended 1981 statutes.

In State v. Johnson, 173 Ariz. 274, 842 P.2d 1287 (1992) Justice Zakot wrote on the importance of re-instructing a jury on the burden of proof involving the same trial judge 4 times, "Even where evidence of guilt appears overwhelming, we have an obligation to ensure that the judicial process is properly accomplished, ... and we are unable to sit idly by while prescribed judicial procedures are ignored out of personal preference or convenience, or for any other unjustifiable cause. There is no suggestion in this record that the trial judge had a valid reason for ignoring the legal precedents previously recanted." State v. Johnson, 173 Ariz. 274, 276, 842 P.2d 1287, 1289 (1992). At no time and in no way was the judicial process properly accomplished "with respect to Dixon's claim nor will anyone find 'a valid reason for ignoring the legal precedents' in Dixon's case.

A judge shall not be swayed by partisan interests, public clamor or fear of criticism, Rule 81, Supreme Court of Arizona, Canon 3(B)(1), Adjudicative Responsibilities. It can be inferred from the circumstances that partisan interests or public clamor or fear of criticism or bad faith in general or all of the above were present and active in continuously denying Dixon a fair and impartial hearing on his claim that M.A.U. police lacked statutory authority to investigate the crime Dixon stands convicted of and as a result, evidence gathered under and after such an illegal conviction is now being used against him in another capital case.

A judge who has knowledge or who receives reliable information that another judge has committed a violation of this code shall take

or initiate appropriate action. Rule 81, Supreme Court of Arizona, Canon 3(D)(1), Disciplinary Responsibilities. Dixon asserts that appropriate action would be to suppress the DNA evidence, dismiss the charges against him and issue a writ of habeas corpus on Dixon's initial 1998 claim of illegal N.A.A. police activity.

It cannot be disputed that on June 10, 1985, certain 1981 statutes should have been applied and interpreted according to basic tenets of statutory construction and the appropriate relief afforded Dixon.

Under the Rule of Law and among men and women of reason, there is a clear and convincing argument that Dixon was and is illegally convicted and as such, the DNA comparison samples he surrendered in 1995 (or 1996) were and are 'tainted' as defined by the United States Supreme Court in Irving Sayre v. United States, supra, Ariz. \_\_\_\_\_, and must be suppressed as fruit gathered from the poisonous tree.

Dixon respectfully requests this court for specific findings of fact and conclusions of law evidentiary hearing and oral arguments notwithstanding.

RESPECTFULLY SUBMITTED this \_\_\_\_\_ day of May, 2008

X

Ms. Vikki M. Liles

Attorney for Defendant.

MICHAEL JEANES, CLERK  
BY *M. Jeanes* DEP  
FILED

2006 JUN 27 PM 3:34

CLARENCE WAYNE DIXON

ASSIGN- TOWERS TAIL

3127 W. GIBSON LANE

PHOENIX, AZ 85009

IN PROPRIA PERSONA

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA  
IN AND FOR THE COUNTY OF MARICOPA

STATE OF ARIZONA,

PLAINTIFF,

VS.

CLARENCE WAYNE DIXON,

DEFENDANT,

NO. CR 2002-01595

MOTION THREE TO RECONSIDER

DENIAL OF CHANGE OF JUDGE

MOTION

(ASSIGNED TO THE HONORABLE  
JAMES M. KEPPLER)

PURSUANT TO 10.1(C), ARIZ. R. OF CRIM. PROCED., DEFENDANT  
ASSENTS JUDGE KEPPLER'S JUNE 20, 2006 DENIAL OF  
DEFENDANT'S JUNE 12, 2006 MOTION TO RECONSIDER DENIAL OF  
CHANGE OF JUDGE MOTION IS PREMATURE AS LACKING THE  
REQUIRED HEARING. DEFENDANT SEEKS TO PRESEVE FOR  
APPEAL, IF NECESSARY, ALLEGATIONS OF INTEREST AND PREJUDICE  
WHICH PREVENT A FAIR AND IMPARTIAL PRE TRIAL AND TRIAL  
ENVIRONMENT; A HEARING WHEREIN DEFENDANT WILL BRING

FORTH TESTIMONY BY DEPUTY PUBLIC DEFENDER JAMES A WILSON THAT INDICATES JUDGE KLEIN'S DISREGARD FOR DEFENDANT'S PROPER POSITION AND LEGAL ARGUMENTS; THAT ON MAY 12, 2006, TOWARDS THE END OF THE PRE-TRIAL CONFERENCE, DEFENDANT ASKED JUDGE KLEIN IF JUDGE KLEIN HAD READ DEFENDANT'S MOTION AND JUDGE KLEIN SAID, "NO".

AS A PROPER DEFENDANT IN A CAPITAL MURDER CASE, THE CRIME OCCURRING SOME 28 YEARS AGO, DEFENDANT'S TASK IS DAUNTING EVEN WITHOUT THE SITTING JUDGE IGNORING DEFENDANT'S PLEADINGS. JUDGE KLEIN'S NEGATIVE RESPONSE TO A DUTY OF OFFICE IS PRIMA FACIE EVIDENCE OF INTEREST AND PREJUDICE. ALLOWING THE STATE'S RESPONSE TO STAND WITHOUT PRIOR JUDICIAL SCRUTINY IS A VIOLATION OF THE CODE OF JUDICIAL CONDUCT, CANON 3, B.7.

IGNORING STATE LAWS, HURRIEDLY DEALING WITH DEFENDANT'S FIRST ORAL ARGUMENT WITH IMPATIENCE WITHOUT PROVOCATION, AND DISMISSING DEFENDANT AND HIS MOTION WITH A CURT "NO" UNDERMINES IMPARTIALITY AND FAIRNESS.

DEFENDANT REQUIRES A HEARING, RULE 10.1(c), ARIZ. R. OF CRIM. PROCED., OR THE COURT GRANT DEFENDANT'S MOTION FOR CHANGE OF JUDGE FOR CAUSE.

SUBMITTED THIS 26TH DAY OF JUNE, 2006

BY Clarence W. Dixon

CLARENCE W. DIXON,

DEFENDANT PRO PER

(2)

**FILED**

**APR 15 2021**

TRACEY K. LINDSEY  
CLERK SUPREME COURT  
BY: \_\_\_\_\_

CLARENCE W. DIXON, 038977

ARIZONA STATE PRISON - Box 8200

FLORENCE, AZ 85132

IN PROPRIA PERSONA

**RECEIVED**

APR 15 2021

CLERK SUPREME COURT

SUPREME COURT OF ARIZONA

**HC-21-0007**

CLARENCE WAYNE DIXON,

) NO

PETITIONER, } PETITION FOR WRIT OF HABEAS

V.S.

} CORPUS

DAVID STINN,

)} DIRECTOR, ARIZONA

DEPARTMENT OF CORRECTIONS,

(DEATH SENTENCE CASE)  
RESPONDENT.

**ER-618**

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RULES/CRIMINAL PROCEDURE, RULE 32

CONSTITUTION, UNITED STATES, 4, 6, 8 AND 14 AMENDMENTS

## I. INTRODUCTION

COMES NOW CLARENCE WAYNE DIXON, AN INMATE ON ARIZONA DEATH ROW, ARIZONA STATE PRISON COMPLEX, FLORENCE, AZ 85132, PRISON

NUMBER 038972, CONVICTED OF FIRST DEGREE MURDER ON JANUARY 24, 2006, SEE STATE V. DIXON, 226 ARIZ. 545 (2011). THIS PETITION IS

SUPPORTED BY THE 4TH, 6TH, 8TH, AND 14TH AMENDMENTS TO THE U.S.

CONSTITUTION, ARTICLE ONE, SECTION 9, ARTICLE 6, SECTION 5, ARTICLE 2,

SECTIONS 4, 8, 14, 15, 23 AND 24 OF THE ARIZONA CONSTITUTION. (PETITIONER

DIXON WOULD HAVE THE COURT NOTE THAT HE IS LEGALLY AND TOTALLY BLIND.

PETITIONER DIXON BEGS THE COURT'S INDULGENCE.)

## II. JURISDICTION.

PETITIONER DIXON ASSERTS HE HAS A CONSTITUTIONAL RIGHT TO BRING FORTH A PETITION FOR WRIT OF HABEAS CORPUS BY A STATE PRISONER BECAUSE HE RELIES ON ARTICLE 2, SECTION 14 OF THE ARIZONA CONSTITUTION WHICH NEGATES THE AUTHORITY OF ANY ENTITY TO SUSPEND THE WRIT OF HABEAS CORPUS. PETITIONER DIXON FURTHER ASSERTS THERE CAN BE NO SUBSTITUTION FOR THE WRIT OF HABEAS CORPUS, ITS SCOPE AND REMEDY BEING THAT THE SUPREME COURT HAS THE POWER TO ISSUE ALL NECESSARY WRITS.

. ARIZONA'S CONSTITUTION AT ARTICLE 2, SECTION 14 PROHIBITS THE SUSPENSION OF THE WRIT OF HABEAS CORPUS BY ANYONE. THE ARIZONA SUPREME COURT'S PROMULGATED RULE 32 EFFECTIVELY DOES JUST THAT BY REQUIRING STATE PRISONERS TO FILE THEIR POST-CONVICTION RELIEF PETITIONS THROUGH THE RULE ESTABLISHED IN A.R.S. CRIMINAL RULE 32

WHICH BY DESIGN REMOVES THE SCOPE AND REMEDIES AVAILABLE IN A

WRIT OF HABEAS CORPUS AND BY IMPOSING LIMITATIONS, DEVIATIONS AND

PRECLUSIONS NOT FOUND IN A WRIT OF HABEAS CORPUS. . SEE ARIZONA

SUPREME COURT RULE 32 ET SEQ.; STATE V. CARRION, 143 ARIZ. 142 (1989).

. IF THE ARIZONA SUPREME COURT DENIES PETITIONER DIXON HIS

CONSTITUTIONAL RIGHT TO THE WRIT OF HABEAS CORPUS, PETITIONER DIXON REQUESTS

THE COURT PROVIDE HIM STATEMENTS OF FACT AND CONCLUSIONS OF LAW

IN SUPPORT OF SUCH DENIAL. PETITIONER DIXON CONCLUDES WITH THE

ASSERTION THAT A CRIMINAL RULE 32 PETITION IS A VASTLY DIFFERENT

DIFFERENT REMEDY THAT ALLOWS THE COURT ALWAYS (COURTS TO EVADE ST.)

SKIPT THE PURPOSE, SCOPE, AND REMEDIES CONSTITUTIONALLY

AFFORDED BY THE WRIT OF HABEAS CORPUS.

### III. ARGUMENT

PETITIONER DIXON CLAIMS THAT HIS 1985 CONVICTIONS FOR SEXUAL ASSAULT AND KIDNAPPING OF ANDREA JANE SALAZAR WERE UNCONSTITUTIONAL AND THAT THE TESTIMONY OF THE VICTIM AJS, A PETITIONER DIXON'S 2007-2008 TRIAL SHOULD HAVE BEEN EXCLUDED AS POISONOUS FRUIT AND HIGHLY PREJUDICIAL AND WAS THE REASON WHY PETITIONER DIXON WAS CONVICTED. THE TRIAL JUDGE WAS COMPLETELY IN ERROR FOR DENYING PETITIONER DIXON'S MOTION PRO SE TO SUPPRESS THE TESTIMONY OF AJS. PETITIONER DIXON AND AND PUBLIC DEFENDER VIRKIL LILES AGREED PRIOR TO TRIAL THAT MS. LILES WOULD BRING THIS CLAIM TO THE TRIAL COURT'S ATTENTION IN EXCHANGE FOR PETITIONER DIXON TAKING A FIELD OF PSYCHOLOGICAL TESTS. MS. LILES FAILED ON HER SIDE OF THIS AGREEMENT. ON APPEAL, IN SEVERAL LETTERS, PETITIONER DIXON

ASKED APPELLATE COUNSEL CONSTANCE OTTANESIAN TO RAISE THIS CLAIM BUT SHE DID NOT DO SO. (APPENDIX AFFIDAVIT / DIXON)

PETITIONER DIXON ALSO BY LETTER ON APPEAL ASKED APPELLATE COUNSEL KERRY DROBAN TO RAISE THIS CLAIM BUT SHE ALSO FAILED TO DO SO. (APPENDIX, AFFIDAVIT / DIXON)

FINALLY, PETITIONER DIXON ASKED APPELLATE COUNSEL PAULA K. HARMS TO RAISE THIS CLAIM BUT SHE FAILED TO DO SO. (APPENDIX, AFFIDAVIT / DIXON).

THIS CLAIM IS CONTROVERSIAL BECAUSE IT CHALLENGES SUCCESSFULLY THE AUTHORITY OF COLLEGE CAMPUS POLICE TO INVESTIGATE FELLOW CRIMES. AT THE TIME OF THE SEXUAL ASSAULT OF AJS, JUNE 10, 1983, ARS 1-215(23), THE DEFINITION OF WHO IS A PEACE OFFICER, DID NOT INCLUDE

UNIVERSITIES CAMPUS POLICE. ALSO ARS 15-1627, AUTHORITY OF  
UNIVERSITY CAMPUS SECURITY OFFICERS, SEVERELY LIMITED THE DUTIES OF  
SECURITY OFFICERS AS TO THEIR DUTIES ON CAMPUS. FELONY CRIME INVESTI-  
-GATIONS WERE NOT INCLUDED IN THE DUTIES OF THESE SECURITY OFFICERS. THE  
NAU SECURITY OFFICERS INVESTIGATED AND TESTIFIED AT TRIAL AS FULLY  
EMPOWERED PEACE OFFICERS. ISSUES OF JURISDICTION MAY BE BROUGHT  
AT ANY TIME. CORPUS JURIS SECONDA, 'JURISDICTION'. THIS CLAIM HAS  
NEVER BEEN DECIDED ON ITS MERITS. NO JUDGE OR JUSTICE HAS  
EVER PROVIDED STATEMENTS OF FACT AND CONCLUSIONS OF LAW IN  
SUPPORT OF THE DENIALS. ON THE MERITS. THE ARIZONA SUPREME  
COURT HAS STATED THAT DEATH PENALTY CASES MUST BE  
SCRUTINIZED AS A MATTER OF GREAT IMPORTANCE. STATE V. BREW  
170 ARIZ. 486 (1982).

PETITIONER DIXON REQUESTS A HEARING TO FURTHER PRESENT  
HIS CLAIM AND IF NEEDED CALL WITNESSES. PETITIONER DIXON ALSO  
REQUESTS THE APPOINTMENT OF COUNSEL MAINLY BECAUSE OF HIS PHYSICAL  
DISABILITY IS CAUSING INORDINATE AMOUNTS OF TIME PUTTING  
HIS CASE TOGETHER AND (AGAINST HIS OWN WILL AND JUDGEMENT)  
ON FELLOW DEATH ROW (INHALES) THE READING OF CONFIDENTIAL  
DOCUMENTS, ETC. IF THE COURT FINDS SIGNIFICANT CAUSE TO  
APPOINT COUNSEL, PETITIONER DIXON WOULD SUGGEST AMANDA C.  
BASS, FEDERAL PUBLIC DEFENDER, BECAUSE SHE IS KNOWLEDGE OF  
THE ENTIRE CASE.

RESPECTFULLY SUBMITTED THIS 9 DAY OF APRIL, 2021.

CLARENCE W. DIXON

CLARENCE. DIXON. 038977

## SUPPLEMENT TO PETITION

ADDITIONALLY, PETITIONER DIXON ASSERTS THE CLAIM OF

INEFFECTIVE ASSISTANCE OF TRIAL COUNSEL, ADVISORY COUNSEL AND APPELLATE COUNSEL. PETITIONER DIXON HAD TO REPRESENT HIMSELF BECAUSE COUNSEL

VIKEI LILES WOULD NOT RAISE A VALID AND CREDIBLE CLAIM THAT SHE SAID SHE

WOULD. ADVISORY COUNSEL COUNTRYMAN, KENNETH AND CARR, NATHANIEL,

FAILED TO ADEQUATELY ASSIST PETITIONER DIXON IN HIS PROSE TRIAL

REPRESENTATION. EXAMPLES OF MISSED ASSISTANCE IS FAILING TO CUE

PETITIONER DIXON WHEN PROSECUTOR JUAN MARTINEZ ERRONEOUSLY

TOLD JURORS THAT HIS DNA WAS ON THE MURDER WEAPON WHEN THE

PROSECUTION'S OWN EXPERT DNA WITNESS COULD NOT TESTIFY TO SUCH. A

PROSECUTOR MARTINEZ ALSO TOLD JUROR IT WAS REGULAR PRACTICE

FOR POLICE INVESTIGATOR TO WALK THROUGH THE CRIME SCENE WITHOUT

GLOVES WHILE PICKING ITEMS UP FOR INSPECTION. IT SHOULD BE NOTED

MR. CRR WAS SUSPENDED FOR FOUR YEARS INVOLVING CONDUCT RELATED TO

PETITIONER DIXON'S TRIAL BUT PETITIONER DIXON HAS BEEN UNABLE

SO FAR TO ASCERTAIN THE PERTINENT FACTS. JUAN MARTINEZ HAS BEEN

DISBARRED FOR UNETHICAL BEHAVIOR IN THE JODI ARIAS TRIAL, AND

APPELLATE COUNSEL WOULD NOT RAISE THE NAU CLAIM DESPITE

PETITIONER DIXON'S ENTREATIES TO DO SO. (APPENDIX AFFIDAVIT, DIXON)

LAST BUT NOT LEAST, BOTH COUNTRIMAN AND CRR WOULD NOT TELL

PETITIONER DIXON WHO A PROSPECTIVE WITNESS LIED TO 1978 POLICE

CONCERNING A INTIMATE RELATIONSHIP HE HAD WITH THE VICTIM. THE

LAW AND THOSE OATHED TO REPRESENT THE LAW WERE NOT ADEQUATELY

ADDERUALLY PRESENCE IN THIS DEATH PENALTY CASE.

THE ORIGINAL AND 7 COPIES WERE

MAILED ON THIS 9 DAY OF APRIL

2021 TO THE CLERK OF THE SUPREME

COURT, 402 STATE COURT BUILDING,

1501 W. WASHINGTON, PHOENIX, AZ

85007, AND

ONE TRUE COPY WAS MAILED ON THE

9 DAY OF APRIL, 2021, TO

MR. DAVID SHANN, DIRECTOR, ARIZONA

DEPT. OF CORRECTIONS, 1601 W. JEFFERSON,

PHOENIX, AZ 85007.

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CLARENCE W. DIXON, 038977

MAY 20 2021

CLERK SUPREME COURT

ARIZONA STATE PRISON, BOX 8200

FLORENCE, AZ 85132

IN PROPRIA PERSONA

ARIZONA SUPREME COURT

CLARENCE WAYNE DIXON,

) NO \_\_\_\_\_

PETITIONER

} SECOND RESPONSE TO STATE'S

v.

} REPLY TO FIRST RESPONSE

DAVID STINN,

)

DIRECTOR, DEPT. OF

}

CORRECTIONS, RESPONDENT.

} (DEATH SENTENCE CASE)

PETITIONER DIXON SECOND RESPONSE TO THE STATES REPLY TO DIXON'S

FIRST RESPONSE WOULD CHALLENGE THE STATES ASSERTION THAT DIXON

PROVIDES NO REASONABLE EXPLANATION WHY HIS PETITION FOR WRIT

OF HABEAS CORPUS SHOULD REMAIN UNDER ARIZONA SUPREME COURT SECURITY

FIRST, ALTHOUGH DIXON CANNOT POINT TO ANYONE SPECIFIC

SENTENCE OR PARAGRAPH IN HIS PRO SE PETITION FOR WRIT OF HABEAS

CORPUS, DIXON INFERS HE CANNOT RECEIVE ADEQUATE

REVIEW OF HIS CLAIM THAT CAMPUS SECURITY OFFICERS DID NOT HAVE

AUTHORITY TO THOROUGHLY OR EVEN PARTIALLY INVESTIGATE THE

JUNE 10, 1985 SEXUAL ASSAULT OF VICTIM JIS WHO TESTIFIED AT

HIS 2007-2008 FIRST DEGREE MURDER/DEATH SENTENCE TRIAL,

DIXON STATED IN HIS PETITION FOR WRIT OF HABEAS CORPUS

THAT NO JUSTICE OR JUDGE HAD EVER PROVIDED STATEMENTS OF

FACT AND CONCLUSIONS OF LAW IN SUPPORT OF THEIR DENIALS.

PETITION, PAGE 6, LINE 8 - 10.

THIS INFERS THAT THE 2007-08 TRIAL COURT ALSO DID NOT  
 PROVIDE FACTS AND LAW IN DENYING DIXON'S CLAIM. THE  
 TRIAL COURT'S ~~REFUSAL~~ OBVIOUS REFUSAL TO APPLY CLEARLY  
 AND PLAINLY STATE LAW AND STATUTES BEGS THE QUESTION WHETHER  
 IT WILL CHANGE <sup>its</sup> DEMONSTRATEDLY PREJUDICED MIND.

THIS REFUSAL TO CORRECTLY APPLY THE <sup>LAW</sup> IN A DEATH SENTENCE  
 CASE EFFECTIVELY FORGETS THE TRIAL COURT'S RULE 32  
 PETITION OBLIGATIONS AND DUTIES.

IN OTHER WORDS, THE STATE'S ASSERTION THAT DIXON IS  
 WITHOUT REASONABLE CAUSE OR EXPLANATION FOR KEEPING HIS PROSE  
 PETITION FOR WRIT OF HABEAS CORPUS UNDER ARIZONA SUPREME COURT

JURISDICTION IS COUNTERED. THERE IS A HIGH PROBABILITY THAT  
THE TRIAL COURT WILL NOT CHANGE ITS POSITION AND THEREFORE  
CLOSE SCRUTINY SHOULD REMAIN WITH THE ARIZONA SUPREME  
COURT.

RESPECTFULLY SUBMITTED THIS 19 DAY OF MAY 2021.

CLARE W. DIXON

CLARE W. DIXON PRO SE

1 Jon M. Sands  
2 Federal Public Defender  
3 District of Arizona  
4 Cary Sandman (AZ Bar No. 004779)  
5 Amanda C. Bass (AL Bar No. 1008H16R)  
6 Eric Zuckerman (PA No. 307979)  
7 Assistant Federal Public Defenders  
8 850 West Adams Street, Suite 201  
9 Phoenix, Arizona 85007  
10 cary\_sandman@fd.org  
11 amanda\_bass@fd.org  
12 eric\_zuckerman@fd.org  
13 602.382.2734 Telephone  
14 602.382.2800 Facsimile

11 **IN THE UNITED STATES DISTRICT COURT**  
12 **FOR THE DISTRICT OF ARIZONA**

13 Clarence Wayne Dixon,  
14 Petitioner,

15 vs.

16 David Shinn, et al.,  
17 Respondents.

No. CV-14-258-PHX-DJH

DEATH-PENALTY CASE

20  
21  
22 **State Court Record**  
23 **Pinal County Superior Court, No. S1100CR202200692**  
24 **Hearing Exhibits 23–39**  
25  
26  
27  
28

CLARENCE W. DIXON, 038977

ARIZONA STATE PRISON, BOX 8200

FLORENCE, AZ 85132

IN PROPRIA PERSONA

IN THE SUPREME COURT OF THE UNITED STATES

CLARENCE WAYNE DIXON,

PETITIONER.

V.

STATE OF ARIZONA, ET AL,

RESPONDENT.

NO. \_\_\_\_\_

PETITION FOR WRIT OF

CERTIORARI TO THE

ARIZONA SUPREME COURT

(DEATH SENTENCE CASE)

# CAPITAL CASE

## QUESTION PRESENTED

SINCE 1991, WHEN PETITIONER DIXON (DIXON) DISCOVERED THAT ARIZONA'S  
UNIVERSITIES CAMPUS POLICE WERE NOT FULLY VESTED WITH LAW ENFORCEMENT  
POWERS, DIXON HAS SOUGHT RELIEF IN COCONINO COUNTY SUPERIOR COURT, MARICOPA  
COUNTY SUPERIOR COURT, COURT OF APPEALS, DIVISION 1, AND THE ARIZONA  
SUPREME COURT. ALL PETITIONS WERE DENIED WITHOUT STATEMENTS OF FACT  
AND CONCLUSIONS OF LAW SUPPORTING THE DENIALS. FOUR POST-CONVICTION RELIEF  
PETITIONS AND ONE SPECIAL ACTION HAVE NOT BROUGHT ANY STATE JUDGE OR JUDGE  
TO READ OR APPLY THE LAW AS IT STOOD IN JUNE 1995.

THE QUESTION PRESENTED BY THIS PETITION FOR WRIT OF HABEAS CORPUS IS

THE FOLLOWING: DOES THE SUPREME COURT HAVE JURISDICTION TO ADJUDICATE

JUSTICE UNDER A THREE-TIER COURT SYSTEM DELIBERATELY AND SYSTEMATICALLY

DEPRIVE A PRISONER SENTENCED TO DEATH THE RIGHT TO DUE PROCESS?

AND EXERCISE PROTECTION BY INTENTIONALLY IGNORING THE LAW WHICH CLEARLY

BENEFITED THE PRISONER?

## LIST OF PARTIES.

ALL PARTIES APPEAR IN THE CAPTION OF THE CASE ON THE COVER

PAGE.

## RELATED CASES

STATE OF ARIZONA V. CLARENCE WAYNE DIXON, NO. 11654, SUPERIOR COURT

OF COCONINO COUNTY DENYING POST-CONVICTION RELIEF

STATE OF ARIZONA V. CLARENCE WAYNE DIXON, NO. 1 CA-CR 92-0171-PR, ARIZ

COURT OF APPEALS, DIVISION ONE, JUDGMENT ENTERED DECEMBER 3, 1992

STATE V. DIXON 153 ARIZ. 131, 735 P.2D 761 (1987), AFFIRMING SENTENCES

AND SENTENCES.

CLARENCE WAYNE DIXON V. DAVID SHINN, NO. HC-21-0007, ARIZONA SUPREME

COURT, DENYING ORIGINAL WRIT OF HABEAS CORPUS ON MAY 21, 2021.

RELATED CASES; CONTINUED

CLARENCE WAYNE DIXON V. DAVID STINN, NO. HC-21-0007, ARIZONA SUPREME

COURT, DENYING MOTION FOR RECONSIDERATION ON JUNE 11, 2021.

STATE OF ARIZONA V. CLARENCE WAYNE DIXON, NO. NO. CR-08-0025-AP-AR

ARIZONA SUPREME COURT, AFFIRMING CONVICTION AND CAPITAL SENTENCE  
ON MAY 6, 2011.

STATE OF ARIZONA V. CLARENCE WAYNE DIXON, NO. CR 2002-01955,

MARICOPA COUNTY SUPERIOR COURT, DENYING POST-CONVICTION RELIEF  
JULY 3, 2013.

STATE OF ARIZONA V. CLARENCE WAYNE DIXON, NO. CR-0238-PC,

ARIZONA SUPREME COURT, DENYING PETITION FOR REVIEW ON FEBRUARY 11, 2014

CLARENCE WAYNE DIXON V. CHARLES RYAN, ET AL, NO. 2:14-CV-

00258-DJA, UNITED STATES DISTRICT COURT, DISTRICT OF ARIZONA,

DENYING PETITION FOR WRIT OF HABEAS CORPUS ON MARCH 16, 2016.

RELATED CASES - CONTINUED

CLARENCE WAYNE DIXON v. CHARLES RYAN, ET AL. NO. 16-99006, 9TH

CIRCUIT COURT OF APPEALS, AFFIRMING DENIAL OF PETITION FOR WRIT OF HABEAS CORPUS ON JULY 26, 2019.

CLARENCE WAYNE DIXON, v. CHARLES RYAN, ET AL. NO. 16-99006, 9TH

CIRCUIT COURT OF APPEALS, DENYING PETITION FOR PANEL AN ORDER

BEING REFERRED ON OCTOBER 18, 2019.

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APPENDIX B — ORDER DENYING MOTION FOR RECONSIDERATION  
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STATUTES AND RULE	
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IN THE SUPREME COURT

OF THE UNITED STATES

PETITION FOR WRIT OF CERTIORARI

PETITIONER PRAYS THAT A WRIT OF CERTIORARI ISSUE TO  
REVIEW THE JUDGMENT BELOW.

THE OPINIONS BELOW

THE OPINION OF THE HIGHEST STATE COURT TO REVIEW THE MERITS

APPEARS ~~AS~~ APPENDIX A TO THE PETITION AND IS UNPUBLISHED

BECAUSE THE PETITION FOR AN ORIGINAL WRIT OF HABEAS CORPUS

WENT DIRECT TO THE ARIZONA SUPREME COURT WHICH ACCEPTED ORIGINAL

JURISDICTION AND DENIED THE PETITION, THEREFORE NO LOWER COURT

OPINION EXISTS.

## JURISDICTION

THE DATE OF WHICH THE HIGHEST STATE COURT DECIDED MY CASE WAS MAY 21, 2021. A COPY OF THAT DECISION APPEARS AT APPENDIX A. A TIMELY PETITION FOR RECONSIDERATION WAS THEREAFTER DENIED ON THE FOLLOWING DATE: JUNE 11, 2021. A COPY OF THE ORDER DENYING RECONSIDERATION APPEARS AT APPENDIX B.

ON NOVEMBER 16, 2021, THE CLERK OF THE UNITED STATES SUPREME COURT, SCOTT S. HARRIS, BY CLAUDE ADLE GRANTED PETITIONER SIXTY ADDITIONAL DAYS TO REFILE THIS PRO SE PETITION.

THE JURISDICTION OF THIS COURT IS INVOKED UNDER 28 USC SECTION

1257 (A).

Z

## CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

UNITED STATES CONSTITUTION, AMENDMENTS 4, 6, 8, AND 14

## STATEMENT OF THE CASE

PETITIONER CLARENCE WAYNE DIXON IS A DEATH ROW PRISONER

WHEN THE STATE OF ARIZONA IS ACTIVELY SEEKING AN EXECUTION DATE.

THIS PETITION FOR WRIT HABEAS CORPUS IS SUPPORTED BY THE FOURTH,

SIXTH, EIGHTH, AND FOURTEENTH AMENDMENTS TO THE UNITED STATES

CONSTITUTION. THIS PETITION IS ALSO SUPPORTED BY THE ARIZONA

CONSTITUTION, ARIZONA STATUTES AND DE FACTO LAW.

BEING TOTALLY BLIND, PETITIONER DIXON BEGS THIS COURT'S

INDULGENCE.

## REASONS FOR GRANTING THE PETITION

ON JANUARY 24, 2008, IN MARICOPA COUNTY SUPERIOR COURT, A JURY FOUND DIXON GUILTY OF THE MURDER OF DENNA L. BORDOIN AND SENTENCED HIM TO DEATH. BEFORE TRIAL, DIXON SOUGHT TO HAVE THE DNA AND WITNESS TESTIMONY EXCLUDED AS POISONOUS FRUIT. SAID MOTION WAS DENIED.

IN JUNE 1985 AJS WAS KIDNAPPED AND SEXUALLY ASSAULTED AND DIXON WAS FOUND GUILTY AND SENTENCED TO SEVEN CONSECUTIVE LIFE SENTENCES FOR THE ASSAULT. STATE V. DIXON 153 ARIZ 151 (1987)

IN 1997 A CRIME DETECTIVE HAD A DNA HIT THAT MATCHED DNA FOUND ON DENNA L. BORDOIN'S PANTIES. STATE V. DIXON, 226 ARIZ. 345 (2011).

WITTH AJS WAS A NORTHERN ARIZONA UNIVERSITY (BIO) ASSAULTED OFF-

CAMPUS. THE ASSAULT OCCURRED ON JUNE 10, 1985. THE ASSAULT

OCCURRED ONE HUNDRED TO ONE HUNDRED-FIFTY YARDS SOUTH OF LONG

TREE ROAD AT THE END APPROXIMATELY TWO TO THREE HUNDRED YARDS

SOUTH OF THE INTERSTATE 4 OVERPASS RUNNING EAST & WEST. THE CRIME

SCENE IS OFF-CAMPUS.

THE NAU SECURITY OFFICERS INVESTIGATED; THEY INTERVIEWED

WITNESSES AND THE VICTIM, GATHERED EVIDENCE, OBTAINED TWO SEARCH WARRANTS

AND A COURT ORDER, AND TESTIFIED AT TRIAL AS POLICE OFFICERS.

THE NAU SECURITY OFFICERS WERE WITHOUT JURISDICTION BECAUSE

ARIZONA STATUTE ALLOWED FOR ONLY ON-CAMPUS INVESTIGATIONS. ~~THE~~

APPENDIX E. THE STATUTE THAT GIVES POWER AND AUTHORITY TO THE

UNIVERSITIES' SECURITY OFFICERS IS STRAIGHT FORWARD: CAMPUS SECURITY

OFFICERS WERE LIMITED TO ON-CAMPUS GROUNDS AND ACTIVITIES. SEE

APPENDIX. THIS LIMITATION IN AUTHORITY AND POWER IS

BUTTRESSED BY ARS 1-215(23)(1981) (DEFINITION OF WHO IS A

PEACE OFFICER.) SEE APPENDIX. THAT STATUTE DOES NOT ALSO

INCLUDE CAMPUS SECURITY OFFICERS IN THE DEFINITION OF WHO IS A  
PEACE OFFICER.

BLACK LETTER LAW CONTAINED IN CAMPUS JURIS SECONDA, 'JURISPRUDENCE'

PLAINLY STATES THAT ISSUES OF JURISDICTION MAY BE BROUGHT AT ANY

TIME. IN 1992 THE ARIZONA SUPREME COURT SAID THAT IT

MUST SCRUTINIZE CLOSELY WHERE A DEATH SENTENCE HAS BEEN

IMPOSED. STATE V. BREWER, 170 ARIZ. 456 (1992).

THE JURORS HEARD THE PROSECUTOR LIE THAT DEGENS DNA WAS ON

THE MURDER WEAPON, HEARD THE PROSECUTOR NOT BE ABLE TO PLACE

DIXON AT THE CRIME SCENE, WAS NEVER GIVEN REASONS WHY THE

BOYFRIENDS BROTHER AND ANOTHER PERSON'S DNA WERE FOUND ON THE

BEDSHEET IN A SOFTBALL SIZE WET SPOT IN CLOSE PROXIMITY TO THE

BODY, WAS NOT TOLD THE VICTIM WAS SEXUALLY ACTIVE BEFORE THE BOY -

FRIENDS TESTIMONIAL KNOWLEDGE: ALL OF WHICH WAS INSTANTLY NEGATED

AS TO REASONABLE DOUBT WHEN AJS TESTIFIED. THE CHALLENGED

AJS VICTIM TESTIMONY ADMITTED 2007-08 TRIAL REMOVED ANY

REASONABLE DOUBT ARGUMENTS IN FACT WITH ITS FATAL PREJUDICE

AND BIAS WEIGHT. THE ARIZONA SUPREME COURT KNOWINGLY AND

WILLINGLY USED AS UNLAWFUL AND UNCONSTITUTIONAL CONVICTION TO

AFFECT A STATUTORY EXECUTION MANIFESTING JUSTICE WITHOUT LAW.

FURTHER, A READING OF A.R.S. § 16-27 (1991) OFFERS CLEAR

GUIDANCE WHERE UNLAWFUL SECURITY OFFICERS WERE HELD, AND A

DELIBERATE MISREADING OF THIS STATUTE BY NOT ONE, BUT TWO AND

AND ALL JUDGES AND JUSTICES INDICATES PRIMA FACIE BIAS AND

PREJUDICE. WHEN A WHOLE BLOCK OF JURISTS MISSTER DELIBERATELY,

THEN SUPREME COURT DECISION IS MANIPULATED. WOULD THIS BE CAUSE

FOR THE SUPREME COURT TO CREATE NEW LAW?

IN A NON-PERFECT CRIMINAL TRIAL, WHERE THE PERFECT PENALTY  
OF EXECUTION IS PRESENT, CONSTITUTIONAL GUARANTEES AND THE RULE OF LAW  
CANNOT BE ABSENT.

DIXON SOUGHT SELF-REPRESENTATION AT TRIAL BECAUSE HIS COURT  
APPOINTED ATTORNEYS WOULD NOT RAISE THE POLICE JURISDICTION CLAIM/  
ISSUE ON. SINCE 1991 DIXON HAS CONFRONTED THIS UNWILLINGNESS

BY DEFENSE COUNSEL(S) TO ADVANCE THIS CLAIM/ISSUE. SEE APPENDIX

F,

#### IV CONCLUSION

DIXON REQUEST THIS COURT REMAND THIS CASE BACK TO  
THE ARIZONA SUPREME COURT WITH INSTRUCTIONS TO ACT IN ACCORDANCE  
WITH THE COURT'S DECISION.

RESPECTFULLY SUBMITTED 7 DAY OF JANUARY 2022.

Clarence W. Dixon

CLARENCE W. DIXON, 038977

CLARENCE W. DIXON, 038977

ARIZONA STATE PRISON BOX 8200

FLORENCE, AZ 85132

IN PROPRIA PERSONA

IN THE SUPREME COURT OF THE UNITED STATES

NO. 21-6820

CLARENCE WAYNE DIXON

PETITIONER

v.

DAVID SKINN, DIRECTOR,

DEPT. OF CORRECTIONS, ET AL

RESPONDENTS.

REPLY TO STATE'S RESPONSE

(DEATH SENTENCE CASE)

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CORPUS JURIS SECUNDUM	6
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## STATEMENT OF THE CASE

IN DECEMBER 2007 AND JANUARY 2008, MR. DIXON REPRESENTING HIMSELF WAS FOUND GUILTY OF THE FIRST DEGREE MURDER OF DEANNA LYNN BURDEN. STATE V. DIXON, 226 ARIZ. 545, (2011). IT SHOULD BE NOTED THAT MR. DIXON REPRESENTED HIMSELF BECAUSE ATTORNEYS VICKI LILES AND GARRETT SIMPSON WOULD NOT ADVOCATE HIS LACK OF POLICE JURISDICTION AND SUBSEQUENT UNLAWFUL VICTIM TESTIMONY AT TRIAL.

MR. DIXON'S UNDERLYING CLAIM IS STRAIGHT FORWARD. IN 1995 N.A.U. CAMPUS POLICE THOROUGHLY INVESTIGATED THE SEXUAL ASSAULT OF A.J.S. THE N.A.U. CAMPUS POLICE OBTAINED EVIDENCE, INTERVIEWED WITNESSES AND THE VICTIM, OBTAINED TWO

TWO SEARCH WARRANTS AND A COURT ORDER, AND TESTIFIED AT

THEIR AS PEACE OFFICERS. AT THE TIME OF THE ASSAULT

AND MR. DIXON'S ARREST, ARIZONA REVISED STATUTE 15-1627 AT

PARAGRAPHS F AND G LIMITED THE CAMPUS POLICE TO TO

ONLY ON-CAMPUS ACTIVITIES AND LAW ENFORCEMENT. THE ASSAULT

OF A.J.S. OCCURRED MORE THAN A MILE SOUTH OF THE CAMPUS.

A.R.S. 1-215(23), DEFINITION OF WHO IS A PEACE OFFICER AT

THE TIME OF THE ASSAULT AND MR. DIXON'S ARREST DID NOT

INCLUDE THE UNIVERSITIES' CAMPUS SECURITY OFFICERS IN ITS

DEFINITION OF WHO IS A PEACE OFFICER;

SINCE 1991 MR. DIXON HAS BROUGHT THIS STRAIGHT  
FORWARD CLAIM TO ARIZONA'S JUDICIARY IN FOUR POST-

CONVICTION RELIEF PETITIONS AND ONE SPECIAL ACTION. ALL

3

THE MANY ARIZONA JUDGES AND JURISTS WHO HAD THE  
OPPORTUNITY AND DUTY TO FOLLOW AND APPLY THE LAW JUDICIALLY  
RECOGNIZING THE APPLICABILITY OF A.R.S. 15-1627(1981) AND  
A.R.S. 1-215(23)(1981) DELIBERATELY AND SYSTEMATICALLY  
DEPRIVED MR. DIXON OF OF CONSTITUTIONAL RIGHTS FOUND IN  
ARIZONA'S AND IN THE UNITED STATES CONSTITUTIONS,  
IN THE STATE'S RESPONSE, ITS USE OF THE WORD  
'ADEQUATE' AS A MEASURE OF THE QUANTITY AND QUALITY OF THE  
JURISPRUDENCE AFFORDED A PRISONER SENTENCED TO DEATH IS  
WOEFULLY WANTING.

## II. ARGUES

MR. SIXON HEREIN REPLIES TO SPECIFIC ARGUMENTS RAISED BY THE STATE RESPONSE OF FEBRUARY 4, 2022. THE PRO SE PETITION FOR WRIT OF HABEAS CORPUS FILED ON APRIL 15, 2021, NEVER LEFT THE ARIZONA SUPREME COURT ORIGINAL JURISDICTION IN ART. II, SECT. 11 OF THE STATE CONSTITUTION. AS SUCH, THE STATE USE OF STATE CRIMINAL RULE 32 ET SEQ. IS NOT APPLICABLE. THE SCOPE AND PURPOSE OF THE WRIT OF HABEAS CORPUS APPLIES ONLY.

ADDITIONALLY, BECAUSE THE STATE SUPREME COURT WAS PRESENTED WITH THE LACK OF N.A.H. POLICE JURISDICTION COUPLED TO THE UNPUNISHED TESTIMONY OF THE 1985 SEXUAL ASSAULT VICTIM AT DANN'S 2007-2008 TRIAL, THIS

5

PRESENTS THE HIGH STATE COURT WITH AN ISSUE OF JURIS-

DICTION WHICH MAY BE RAISED AT ANY TIME. THE STATE DID NOT

ADDRESS THIS ISSUE IN ITS RESPONSE.

AFTER HIS CONVICTION AND SENTENCE OF DEATH IN JANUARY

2008, MR. DIXON WAS REPRESENTED ON DIRECT APPEAL BY

CONSTANCE O'HANSTAN, KERRIE DROBAN, SARAH STONE, AND KAREN

WILKINSON. ALL THESE ATTORNEYS WERE CONTACTED BY MR.

DIXON VIA MAIL AND TOLD OF THE CLAIM THAT THE N.A.A.

POLICE LACKED JURISDICTION IN 1985 AND THAT THE VICTIM'S

TESTIMONY IN HIS 2007-2008 FIRST DEGREE MURDER TRIAL

WAS UNLAWFUL. ALL FOUR ATTORNEYS REFUSED TO INCLUDE

THIS CLAIM IN THEIR APPEAL IN STATE AND FEDERAL

PROCEEDINGS. SEE APPENDIX F.

6  
IT IS WORTH NOTING THAT ISSUES OF JURISDICTION MAY BE BROUGHT  
AT ANY TIME. CORPUS JURIS SECUNDUM, 'JURISDICTION'.

THE STATE ASSETS IN ITS RESPONSE THAT MR. DIXON DID NOT  
PRESENT A FEDERAL QUESTION. BUT THAT ARGUMENT IGNORES THE  
REASONS ADVANCED BY MR. DIXON FOR GRANTING CERTIORARI ON PAGES  
3 THROUGH 10 OF MR. DIXON'S PETITION FOR CERTIORARI.  
THOSE REASONS ARISE UNDER THE UNITED STATES CONSTITUTION,  
SPECIFICALLY THE FOURTH, SIXTH, EIGHTH, AND FOURTEENTH  
AMENDMENTS. ID.

### III. CONCLUSION.

THE PRINCIPLE DUTY AND OBLIGATION OF THE STATE  
ATTORNEY GENERAL IS THE PROPER ADMINISTRATION OF JUSTICE.  
BY ALLOWING PROSECUTORS AND THE JUDICIARY TO IGNORE STATE

7  
STATUTES AND UPHOLD UNLAWFUL AND UNCONSTITUTIONAL

CONVICTIONS, MR. DIXON ASSERTS THAT THERE IS A NON-

COMPLIANCE WITH AND A REDEFINING OF THE MEANING OF

DUTY AND OBLIGATION ERRONEOUSLY AND SUBJECTIVELY TILTING

THE SCALES OF JUSTICE TOWARDS GUILT AND CONVICTION.

MR. DIXON REQUEST THAT THE COURT REMAND HIS CASE

FOR RETRIAL OR REVERSAL OF THE CONVICTION CONSISTENT WITH

THIS COURT'S LAST RESORT ADMINISTRATION OF JUSTICE.

DATED THIS 16TH DAY OF FEBRUARY 2022.

Clarence W. Dixon

CLARENCE W. DIXON (28977)

CONFIDENTIAL

Arizona Commission on Judicial Conduct  
1501 W. Washington Street, Suite 229  
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

### HOW TO FILE A COMPLAINT AGAINST A JUDGE

To file a complaint against a judge, complete this form and send it to the Commission on Judicial Conduct at the address above. The information you provide will be used to evaluate and investigate your allegations.

To learn more about the purpose and jurisdiction of the commission and the types of allegations it can investigate, read the enclosed brochure or visit our website at [www.azcourts.gov/azcjc](http://www.azcourts.gov/azcjc). A copy of the commission's rules and the Code of Judicial Conduct can be printed from the website.

Under the rules approved by the Arizona Supreme Court, complaints may be made public at the conclusion of their review by the commission or upon the filing of a formal complaint against a judge. If a complaint is dismissed, all personal information will be redacted from what is made public.

Please provide the following information

1. Name: CHARLES W. DIXON #038977
2. Mailing Address: P.O. Box 8200  
City: Florence State: AZ Zip Code: 85132
3. Landline phone: AZ SCT JUSTICES Cell phone: PHOENIX
4. Judge's name: STATE V. DIXON Location: PHOENIX
5. Court: ☐ municipal ☐ justice ☐ superior ☐ court of appeals ☒ supreme court
6. Did you have a case before this judge? ☒ Yes ☐ No. If yes, is the case still pending? ☐ Yes ☐ No  
a. Case name and number: STATE V. DIXON; DIXON V. SKINN  
b. List any attorneys who appeared in the case:  
EN PROTEA PERSONA
- c. List names and phone numbers of any witnesses who observed the judge's conduct:

N/A

7. I understand the commission **cannot** reverse court orders or assign a new judge to a case: ☒ Yes ☐ No
8. Please read the following statement and sign on the line below:

I affirm, under penalty of perjury, that the foregoing information and the allegations contained in the attached complaint are true.

Charles W. Dixon  
Signature

APR. 8, 2012  
Date

CONFIDENTIAL

Arizona Commission on Judicial Conduct  
501 W. Washington Street, Suite 229  
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

--

COMPLAINT AGAINST A JUDGE

Name: CLARENCE DIXON Judge's Name: AZ SET JUSTICES

**Instructions:** Use this form or plain paper of the same size to file a complaint. Describe in your own words what you believe the judge did that constitutes judicial misconduct. Be specific and list all of the names, dates, times, and places that will help the commission understand your concerns. Additional pages may be attached along with copies (not originals) of relevant court documents. Please complete one side of the paper only, and keep a copy of the complaint for your records.

( See Attached )

## COMPLAINT AGAINST A JUDGE

CLARENCE WAKE DIXON, COMPLAINANT

ANDREW GOULD, JUSTICE, ARIZONA SUPREME COURT

I AM FILING A COMPLAINT AGAINST JUSTICE GOULD FOR HIS

FAILURE TO CORRECTLY APPLY RELEVANT STATUTES AND FAILING TO

FOLLOW REQUIRED JUDICIAL PROCESS WHILE ALLOWING

BLATANTLY INCORRECT INCORRECT LOWER COURT DECISIONS TO

STAND IN MY ROSE PETITION FOR WRIT OF HABEAS CORPUS

JUSTICE GOULD REFUSED TO ACKNOWLEDGE AND APPEAL THROUGH

CLOSE SCRUTINY I.A.S. 1-215(23)(1981) AND A.R.S. 15-1627 (1981)

BUT FULLY ACKNOWLEDGES THE APPLICATION OF ARIZONA'S

DEATH SENTENCE STATUTES. EQUAL PROTECTION, DUE PROCESS,

AND FAIRNESS CANNOT BE FOUND IN JUSTICE GOULD'S DECISION TO DENY

2  
MY PETITION FOR WRIT OF HABEAS CORPUS IN THE SUPREME COURT.

THIS VIOLATION CAN BE FOUND IN THE CODE OF JUDICIAL CONDUCT  
CANON TWO IMPARTIALITY AND FAIRNESS.

I HAVE PROVIDED THE COMMISSION ON JUDICIAL CONDUCT A COPY OF THE  
LAW AND ARGUMENTS PORTION OF MY PETITION FOR WRIT OF HABEAS  
CORPUS AND COPIES OF THE TWO POINTERS RELEVANT PRI ARSON  
STATUTES, ARS 1-215(23) AND ARS 15-1627 AT APPENDIX A.

I STRONGLY REQUEST THAT JUSTICE ANDREW GOULD BE  
DISBARRED. HIS DENIAL OF MY CLAIM WAS COMPLETELY LACKING IN  
PROFESSIONAL WORKMANSHIP AND HIS ADHERENCE TO HIS OATH TO  
OFFICE. HIS CONDUCT OR LACK THEREOF WILL ALLOW THE  
STATE TO INFLICT A CONSTITUTIONALLY INFIRM IF NOT ILLEGAL  
AND IMMORAL HOMICIDE UPON MY PERSON AND BODY.

3  
THIS COMPLAINT IS SUBMITTED ON THIS 11<sup>th</sup> DAY OF APRIL

2022.

Clarence W. Dixon

## CONFIDENTIAL

Arizona Commission on Judicial Conduct  
1501 W. Washington Street, Suite 229  
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

## HOW TO FILE A COMPLAINT AGAINST A JUDGE

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Under the rules approved by the Arizona Supreme Court, complaints may be made public at the conclusion of their review by the commission or upon the filing of a formal complaint against a judge. If a complaint is dismissed, all personal information will be redacted from what is made public.

Please provide the following information

1. Name: CHARLES W. DIXON #0389772. Mailing Address: P.O. Box 8200City: Florence State: AZ Zip Code: 851323. Landline phone: AZ SCT JUSTICES Cell phone: PHOENIX4. Judge's name: STATE V. DIXON Location: PHOENIX5. Court: ☐ municipal ☐ justice ☐ superior ☐ court of appeals ☒ supreme court6. Did you have a case before this judge? ☒ Yes ☐ No. If yes, is the case still pending? ☐ Yes ☐ Noa. Case name and number: STATE V. DIXON; DIXON V. SKINN

b. List any attorneys who appeared in the case:

EN PROTEA PERSONA

c. List names and phone numbers of any witnesses who observed the judge's conduct:

N/A7. I understand the commission **cannot** reverse court orders or assign a new judge to a case: ☒ Yes ☐ No

8. Please read the following statement and sign on the line below:

I affirm, under penalty of perjury, that the foregoing information and the allegations contained in the attached complaint are true.

Charles W. Dixon  
Signature

APR. 8 2012  
Date

CONFIDENTIAL

Arizona Commission on Judicial Conduct  
501 W. Washington Street, Suite 229  
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

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COMPLAINT AGAINST A JUDGE

Name: CLARENCE DIXON Judge's Name: AZ SET JUSTICES

**Instructions:** Use this form or plain paper of the same size to file a complaint. Describe in your own words what you believe the judge did that constitutes judicial misconduct. Be specific and list all of the names, dates, times, and places that will help the commission understand your concerns. Additional pages may be attached along with copies (not originals) of relevant court documents. Please complete one side of the paper only, and keep a copy of the complaint for your records.

(See Attached)

# COMPLAINT AGAINST A JUDGE

CLARENCE WAYNE DIXON, COMPLAINANT

ANN SCOTT TIMMER, SUPREME COURT JUSTICE

I AM FILING A COMPLAINT AGAINST JUSTICE TIMMER FOR FAILING TO  
APPLY RELEVANT STATUTES AND JUDICIAL PROCESS WHILE ALLOWING  
BLATANTLY ERROR-FILLED LOWER COURT DECISIONS TO STAND IN MY  
PRO SE PETITION FOR WRIT OF HABEAS CORPUS

JUSTICE TIMMER REFUSED TO ACKNOWLEDGE AND APPLY THERE

CLOSE SCRUTINY. A.R.S. 1-215(23)(1981) AND A.R.S. 15-1627(1981)

FULLY ACKNOWLEDGES AND IS ALLOWING THE APPLICATION AND  
IMPLEMENTATION OF ARIZONA'S DEATH SENTENCE STATUTES.

EQUAL PROTECTION, DUE PROCESS AND FAIRNESS CANNOT BE FOUND

IN JUSTICE TIMMER'S DENIAL OF MY PRO SE PETITION. THIS

2  
IS A VIOLATION OF CANON TWO, CODE OF JUDICIAL CONDUCT, IMPARTIALITY  
AND FAIRNESS.

I HAVE PROVIDED THE COMMISSION WITH A COPY OF THE LAW AND  
ARGUMENTS PORTION OF MY PETITION FOR WRIT OF HABEAS CORPUS AND  
THE COPIES OF THE 1981 STATUTES, 1-2115(23) AND 15-1607, AT  
APPENDIX A.

I STRONGLY REQUEST THAT JUSTICE TURNER'S ACTION OR INACTION IN  
CONSIDERING MY PETITION FOR WRIT OF HABEAS CORPUS BE GROUNDS FOR  
DISBARMENT. THIS LACK OF APPROPRIATE AND PROFESSIONAL  
CONDUCT ALLOWS FOR THE UNCONSTITUTIONALLY INFIRM, ILLEGAL  
AND IMMORAL GHOULISH INFLECTION OF A HOMICIDE UPON MY PERSON  
AND BODY. (THE ARIZONA CONSTITUTION EMPOWERS EACH SUPREME  
COURT JUSTICE HIS OR HER INDIVIDUAL CHOICE TO GRANT WRITS OF

3  
(HAB As corrupts.)

SUBMITTED THIS 11<sup>th</sup> DAY OF APRIL 2022.

Chene W. Dixon

## CONFIDENTIAL

Arizona Commission on Judicial Conduct  
1501 W. Washington Street, Suite 229  
Phoenix, Arizona 85007

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## HOW TO FILE A COMPLAINT AGAINST A JUDGE

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To learn more about the purpose and jurisdiction of the commission and the types of allegations it can investigate, read the enclosed brochure or visit our website at [www.azcourts.gov/azcjc](http://www.azcourts.gov/azcjc). A copy of the commission's rules and the Code of Judicial Conduct can be printed from the website.

Under the rules approved by the Arizona Supreme Court, complaints may be made public at the conclusion of their review by the commission or upon the filing of a formal complaint against a judge. If a complaint is dismissed, all personal information will be redacted from what is made public.

Please provide the following information

1. Name: CHARLES W. DIXON #0389772. Mailing Address: P.O. Box 8200City: Florence State: AZ Zip Code: 851323. Landline phone: AZ SCT JUSTICES Cell phone: PHOENIX4. Judge's name: AZ SCT JUSTICES Location: PHOENIX5. Court: ☐ municipal ☐ justice ☐ superior ☐ court of appeals ☒ supreme court6. Did you have a case before this judge? ☒ Yes ☐ No. If yes, is the case still pending? ☐ Yes ☐ Noa. Case name and number: STATE V. DIXON; DIXON V. SKINN

b. List any attorneys who appeared in the case:

EN PROTEA PERSONA

c. List names and phone numbers of any witnesses who observed the judge's conduct:

N/A7. I understand the commission cannot reverse court orders or assign a new judge to a case: ☒ Yes ☐ No

8. Please read the following statement and sign on the line below:

I affirm, under penalty of perjury, that the foregoing information and the allegations contained in the attached complaint are true.

Charles W. Dixon  
Signature

APR. 8 2012  
Date

CONFIDENTIAL

Arizona Commission on Judicial Conduct  
501 W. Washington Street, Suite 229  
Phoenix, Arizona 85007

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COMPLAINT AGAINST A JUDGE

Name: CLARENCE DIXON Judge's Name: AZ SET JUSTICES

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(See Attached)

## COMPLAINT AGAINST A JUDGE

CLARENCE WAYNE DIXON, COMPLAINANT

KATHRYN KING, SUPREME COURT JUSTICE

I AM FILING A COMPLAINT AGAINST JUSTICE KING FOR FAILING TO APPLY  
RELEVANT STATUTES AND APPROPRIATE JUDICIAL PROCESS, WHILE ALLOWING  
BUT NOT ERRORING LOWER STATE COURT DECISIONS TO STAND. IN MY RO &  
PETITION FOR WRIT OF HABEAS CORPUS, JUSTICE KING REFUSED TO ACKNOWLEDGE  
AND APPLY THROUGH CLOSE SCRUTINY AR.S. 1-215(23)(1981) AND AR.S. 15-167(1981)  
BUT FULLY ACKNOWLEDGES AND IS ALLOWING IMPLEMENTATION OF ARIZONA'S  
DEATH SENTENCE STATUTES. ~~THE~~ EQUAL PROTECTION, DUE PROCESS AND  
FAIRNESS CANNOT BE FOUND IN JUSTICE KING'S DENIAL OF MY PETITION FOR  
WRIT OF HABEAS CORPUS.

JUSTICE KING BIAS AND PREJUDICE IN MY CASE IS A VIOLATION OF

CANON TWO, CODE OF JUDICIAL CONDUCT, IMPARTIALITY AND FAIRNESS.

I HAVE PROVIDED THE COMMISSION WITH THE LAW AND ARGUMENTS  
PORTION OF MY PRO SE PETITION FOR WRIT OF HABEAS CORPUS  
AND STATUTES A.R.S. 1-2623 (1991) AND A.R.S. 15-107 (1991) IN THE  
ATTACHED APPENDIX A.

I STRONGLY REQUEST THAT THE COMMISSION ON JUDICIAL CONDUCT FIND  
JUSTICE KING'S DENIAL OF MY PETITION FOR WRIT OF HABEAS CORPUS TO BE  
COMPLETELY LACKING IN PROFESSIONAL WORKMANSHIP AND AVOIDANCE  
OF HER OATH OF OFFICE. JUSTICE KING SHOULD THEREFORE BE DISBARRED.  
HER LACK OF IMPARTIALITY AND FAIRNESS WILL HAVE CAUSE TO IMPACT A  
CONSTITUTIONALLY INFIRM IF NOT ILLEGAL IF NOT IMMORAL MURDER UPON A  
PERSON AND BODY.

THE ARIZONA CONSTITUTION GIVES EACH JUSTICE INDIVIDUALLY THE POWER

3  
TO GRANT WRITS OF HABEAS CORPUS.

I AM 95% BLIND AND BEG THE COMMISSIONER'S INDULGENCE.

SUBMITTED THIS 11<sup>th</sup> DAY OF APRIL 2022.

Charm Wilson

## CONFIDENTIAL

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1501 W. Washington Street, Suite 229  
Phoenix, Arizona 85007

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b. List any attorneys who appeared in the case:

EN PROTEA PERSONA

c. List names and phone numbers of any witnesses who observed the judge's conduct:

N/A7. I understand the commission **cannot** reverse court orders or assign a new judge to a case: ☒ Yes ☐ No

8. Please read the following statement and sign on the line below:

I affirm, under penalty of perjury, that the foregoing information and the allegations contained in the attached complaint are true.

Charles W. Dixon  
Signature

APR. 8 2012  
Date

CONFIDENTIAL

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COMPLAINT AGAINST A JUDGE

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(See Attached)

## COMPLAINT AGAINST A JUDGE

CLARENCE WAYNE DIXON, COMPLAINANT

WILLIAM MONTGOMERY, JUSTICE, ARIZONA SUPREME COURT

I AM FILING A COMPLAINT AGAINST JUSTICE MONTGOMERY FOR HIS FAILURE TO CORRECTLY APPLY RELEVANT STATUTES AND FOLLOW JUDICIAL PROCESS. WHILE ALLOWING ERROR-FILLED LOWER STATE COURT DECISION TO STAND... IN MY ROSE PETITION FOR WRIT OF HABEAS CORPUS.

JUSTICE REFUSED TO APPLY AND ACKNOWLEDGE... THROUGH CLOSE SCRUTINY. A.R.S. 1-215(23)(1981) AND A.R.S. 15-1627(1981).

WHILE IGNORING THESE RELEVANT STATUTES CONTAINED WITHIN MY CLAIM, JUSTICE MONTGOMERY READILY RECOGNIZES AND ALLOWS THE IMPLEMENTATION OF ARIZONA'S DEATH SENTENCE STATUTES.

EQUAL PROTECTION, DUE PROCESS AND FAIRNESS CANNOT BE FOUND

2  
FOUND IN JUSTICE MONTGOMERY'S DENIAL OF MY PETITION FOR WRIT  
OF HABEAS CORPUS.

JUSTICE MONTGOMERY'S BIAS AND PREJUDICE IN MY CASE IS A  
VIOLATION OF CANON TWO, CODE OF JUDICIAL CONDUCT, IMPARTIALITY AND  
FAIRNESS.

I HAVE PROVIDED THE COMMISSION ON JUDICIAL CONDUCT WITH THE  
LAW AND ARGUMENT PORTION OF MY PRO SE PETITION FOR WRIT OF HABEAS  
CORPUS AND COPIES OF 1981 STATUTES 1-21623 AND 15-1627 IN  
THE ATTACHED APPENDIX A.

I STRONGLY REQUEST THE COMMISSION ON JUDICIAL CONDUCT  
FIND JUSTICE MONTGOMERY'S DENIAL OF MY PETITION TO BE SEVERELY  
LACKING IN PROFESSIONAL WORKMANSHIP AND A VIOLATION OF HIS OATH  
OFFICE IN ADDITION TO A CODE VIOLATION.

3  
JUSTICE MONTGOMERY'S CONDUCT ALLOWS THE STATE BY

WAY OF THE DEPARTMENT OF CORRECTIONS TO GHOULISHLY INFLECT A

CONSTITUTIONAL INFIRM, ILLEGAL AND UNLAWFUL HOMICIDE UPON MY PERSON

AND BODY. (THE ARIZONA CONSTITUTION EMPOWERS EACH SUPREME COURT

JUSTICE . WITH THE GRANTING OF A WRIT OF HABEAS

CORPUS.)

SUBMITTED THIS 11<sup>th</sup> DAY OF APRIL 2022.

Chame W. Dixon

1  
APRIL 16, 2022

DEAR COMMISSION CHAIRPERSON,

QUITE RECENTLY, I SUBMITTED COMPLAINTS REGARDING ARIZONA  
SUPREME COURT JUSTICES AND I REQUEST THAT THESE SUPREME  
COURT JUSTICES BE DEBARRED. IT IS MY UNDERSTANDING THAT SIX OF  
THE TWELVE MEMBERS OF THE COMMISSION WERE APPOINTED BY THE  
ARIZONA SUPREME COURT, AND I STRONGLY BELIEVE THESE SIX  
MEMBERS SHOULD SERIOUSLY CONSIDER RECUSING THEMSELVES  
REGARDING MY COMPLAINT AGAINST THE ARIZONA SUPREME COURT  
MEMBERS.

I ~~AM~~ WANT TO REITERATE THAT I AM REQUESTING DIS-  
BARMENT ONLY, THERE IS NO CONFUSION REGARDING  
OTHER AVENUES OF REPROVEMENT.

IF THIS COMMISSION CANNOT, WILL NOT, OR IS UNABLE

TO DISBAR THESE SUPREME COURT MEMBERS, I REQUEST  
IMMEDIATE NOTIFICATION SO THAT I MAY TAKE MY COMPLAINT TO THE  
ARIZONA BAR ASSOCIATION.

I FIND IT UNCONSCIONABLE THAT THESE ARIZONA SUPREME  
COURT MEMBERS WOULD LACK PROFESSIONAL INTEGRITY INVOLVING A  
CAPITAL CASE. THEIR LACK OF IMPARTIALITY AND FAIRNESS, ~~LEADS~~  
~~LEAD~~ DIRECTLY TO AN EXTRA-JUDICIAL KILLING, AN ILLEGAL AND  
IMMORAL MURDER CARRIED OUT IN THE NAME OF AND FOR THE GOOD  
PEOPLE OF ARIZONA.

THANK YOU FOR CONSIDERING THIS LETTER. I AM SINCERELY...

Clarence W. Dixon, 038977

**Carlos J. Vega**  
CURRICULUM VITAE

FOREIGN LANGUAGES  
**Spanish (fluent)**

EDUCATION

**Sept. '78 -- Dec. '81 -- Nova Southeastern University, Ft. Lauderdale, FL.—  
Degree Awarded July 1982, Doctor of Psychology from The School of Professional Psychology.**

**Sept. '77-July '78 -- Nova Southeastern University, Ft. Lauderdale, FL. Degree awarded: Master of Science in Psychology (Counseling and Guidance) from the Behavioral Science Program.**

**Sept. '75 -- May '77 -- University of Miami, Coral Gables, FL. Degree awarded: Bachelor of Arts, Major in Psychology and Minor in French.**

LICENSES AND PROFESSIONAL AFFILIATIONS

**State of Arizona licensed (Clinical) psychologist since May 1983 (license #1020).**

**Arizona Board of Psychologist Oral Examiner (1997)**

**Past Chair for East Valley Behavior Health Assoc Quality Assurance Committee.**

WORK EXPERIENCE

**Mar. '87 -- present --Full time private practice.**

**Aug. '82 -- April '87 --Clinical Director and Clinical Psychologist at the Behavioral Health Agency of Central Arizona. ( Jan. '87) Part-time private practice in Phoenix, St. Luke's Medical Building #406.**

**Sept. '81 --July '82 --Staff Clinical Psychologist at the Miami Mental Health Center, located in Miami FL.**

**Sept. '80 -- Sept. '81 --Clinical Psychologist Internship at Miami Mental Health Center.**

RESEARCH/PROJECTS/PRESENTATIONS

**Presented recently on the effects of psychological trauma at CIBHS, a state wide behavioral health agency. several DSM III-R seminars and an interviewing technique seminar to local professionals, a DSM IV seminar to case managers, and two seminars on Psych. Testing to social service providers. Conducted study subsidized by DES of MMPI (personality testing) findings on maltreating mothers in Pinal and Gila Counties. Presented study of human figure drawings of sexually abused girls at NCCMHS. Have also made formal presentations in Spanish such as one on EMG biofeedback in San Juan, Puerto Rico to Puerto Rican graduate students.**

MAJOR EDUCATIONAL SEMINARS ATTENDED

**(A few of the recent ones)**

**Training MH Experts in Legal Competency and Restoration. Current Trends in Psychopharmacology. Conducting Effective Mental Status and Risk Assessment. Two of the Annual US Psychiatric and Mental Health Congresses. Recent MMPI-2 & MMPI-A symposia by Dr. Butcher. Dr. Amen's The Healing Brain. Innovations in Addiction Treatment & Behavioral Health Care.**

**CARLOS J. VEGA, PSY. D.**  
**PSYCHOLOGIST**  
**1298 E. AVENIDA GRANDE**  
**CASA GRANDE, AZ 85122**  
**(520) 836-1835**  
**(520) 876-4653 FAX**  
**drcjvega@gmail.com**

**PSYCHOLOGICAL EVALUATION**  
**CONFIDENTIAL**  
**FOR PROFESSIONAL USE ONLY**

**NAME:** Clarence W Dixon  
**DATE OF BIRTH:**  
**AGE:** 66 years old  
**DATE OF EVALUATION:** April 23, 2022  
**EVALUATOR:** Carlos J. Vega, Psy.D.  
**CASE NUMBER:** CR2002-019595

**REFERAL STATEMENT**

Clarence is a 66-year-old Native American male who was court ordered for a psychological evaluation involving a competency matter that exceeds the usual issues covered by a general Rule 11 Exam. With guidance from the Attorney General's Office this evaluation needs to address the following questions:

1. Is Clarence Dixon's mental state so distorted, or his concept of reality so impaired, that he lacks a rational understanding of the State's rationale for his execution?
2. Is Clarence Dixon, due to a mental disease or defect, presently unaware that he is to be punished for the crime of murder or unaware that the impending punishment for that crime is death?
- 3.

This report addresses Clarence's general psychological functioning, and the referral concerns are summarily addressed in the final section of this report.

**ASSESSMENT PROCEDURES**

Clinical Interview \*Mental Status Examination \*Competency Inquiry \*Review of Reports Available

**RESULTS OF ASSESSMENT PROCEDURES**

Documents reviewed include the "Motion to Determine Mental Competency to be Executed" dated April 8, 2022. The motion indicates that "...Clarence Dixon is a 66-year-old legally blind man of Native American ancestry, who has long suffered from a psychotic disorder—paranoid schizophrenia. Previously, an Arizona court determined that he was mentally incompetent and legally insane. Mr. Dixon has a documented history of delusions, auditory and visual hallucinations, and paranoid ideation. On April 5, 2022, the Arizona Supreme Court issued a warrant of execution scheduling Mr. Dixon's execution date for May 11, 2022...Mr. Dixon's execution by the State of Arizona will violate A.R.S. § 13-4021, which prohibits the State from executing an individual who is mentally incompetent to be executed. Mr. Dixon's execution will also violate the Eighth Amendment to the United States Constitution...which "prohibit[s] a State from carrying out a sentence of death upon a prisoner who is insane." As set forth below, Mr. Dixon's mental illness renders him incompetent to be executed by depriving him of the ability to rationally

comprehend the meaning and purpose of the punishment the State of Arizona seeks to exact by his execution—that is, Mr. Dixon’s mental illness thwarts his ability to form a rational understanding of the State’s reasons for his execution... Mr. Dixon has a long and well-documented history of severe mental illness, including prior findings of incompetency, a legal finding of not guilty by reason of insanity (NGRI), and multiple diagnoses of paranoid schizophrenia... in September 1977, Mr. Dixon was found incompetent by two different court-appointed psychiatrists... He was released from ASH approximately two months later, after a third psychiatrist found he regained competency to stand trial. At trial for the 1977 assault, Mr. Dixon was found NGRI and released...recognizing Mr. Dixon’s serious mental illness...the trial judge also ordered the State to commence civil commitment proceedings. The murder, for which Mr. Dixon is sentenced to death in these current proceedings, occurred on January 7, 1978, less than 48 hours after the trial judge had ordered the State to institute civil commitment proceedings... Subsequently, in 1981, a psychological evaluation of Mr. Dixon administered by the Arizona Department of Corrections described symptoms consistent with his paranoid schizophrenic psychotic disorder...and that he experiences “grossly disturbed perceptual and thought patterns, clear paranoid ideation, feelings of frustration, and moderate agitation...producing inefficiency of intellectual functioning...”

Documents reviewed reveal that in May 2001 Tempe Police Department matched DNA evidence to Clarence W Dixon, of the 1978 murder of 21-year-old Arizona State University Student Deana Bowdoin. Dixon was serving life sentences in prison for a 1986 sexual assault. Dixon, at one point had been released on parole in March 1985, and on April 2, he grabbed a woman in the parking lot at Northern Arizona University, holding a knife to her throat. On June 10, he grabbed a female jogger on the road near NAU. While holding her at knife point, he walked her to the woods where he tied her hands and sexually assaulted the woman. Dixon was arrested, convicted, and sentenced to seven consecutive life terms. A prior psychiatric evaluation indicated that “Mr. Dixon reported no involvement with the Juvenile Justice System...”, however there are documents that indicate that as a child he was cruel to animals and may have molested his sister. “...He said he was first convicted of “DUI's" when he was eighteen and nineteen in Gallup, NM. He also stated that he was charged with soliciting prostitution in 1978. He said that he spent five days in jail...” In 1977 he assaulted a young girl whom he thought was his ex-wife or (she looked like his ex-wife)...” In 2005, Clarence was charged with the 1978 sexual assault and murder of a university student. In 1985 Clarence had been convicted in Coconino County of seven counts arising from the sexual assault of a student on the campus at NAU. He was on parole at the time of these offenses and therefore he received seven consecutive life sentences in that case.

Aside, and at times related to Clarence history of antisociality is his admitted history of psychoactive substance abuse. Documents reviewed indicated that Clarence was around 16 years old when he began to use alcohol. He stated that eventually his drinking increased to daily use of etoh. He reported that this went on from 1977 until September 1978 and that it included usually drinking beer but at times he would drink an entire bottle of vodka. He acknowledged to having had frequent blackouts "about once every two or three weeks" from the vodka.

I met with Clarence on April 22 via Google Meet video set up. Clarence is being housed at the Browning Unit at the DOC in Florence. I introduced myself and went over the reason for my visit. Clarence was immediately amenable and cooperative. He stated that he had been in "the DOC for 36 years “and added that he was "on death row” and he was going to be executed “in 11 days.”

Even though his psychosocial history is well documented, to help establish a good rapport I obtained a summary of his background information. Clarence reported that he was from Fort Defiance in Arizona. He stated that this was approximately 100 miles from the four corners area. He reported that he has two sisters

and three brothers and acknowledged that he wasn't close to any of them and had lost contact. It's been documented in prior evaluations that Clarence never really felt connected to anyone. He went on to describe himself as a loner. He reiterated that which has been documented in terms of not having any friends. He did mention having had a friend in the sixth grade and that the relationship lasted several years, but admits that this relationship also ended decades ago. With regards to his education, he said that he was an average student in high school and that he was "one semester away from a bachelor's degree in fine arts".

With regards to employment, he stated that he worked approximately a total of "four or five years" and that he was an auto mechanic. He added that he worked two years in the reservation and "two years off [the reservation]". He stated that he enjoyed working.

He was married at one time and was with his wife for about two years and denied having children. Documents indicate that he had a very troublesome marriage and she divorced him when incarcerated.

Clarence reported not having had any dealings with behavioral health services growing up. However, documents indicate that he reportedly suffered considerable depression as a youngster. In addition, he describes himself as being avoidant, very shy and reticent in his interpersonal dealings. There's also reports of Clarence having been cruel to animals and having molested his sister. The latter is something he subsequently denied. At any rate, he recalls that he first dealt with behavioral health professionals in 1977 when he was referred to "two psychiatrists" for competency evaluation. The latter was in connection to having "attacked a girl with a pipe". Client stated that he did not know his diagnosis but knew that the mental health professionals stated that he had "deep psychological problems". He does not recall ever having been offered medication and he reports that he never took psychotropic medication. There is a psychological report dated 1981 suggesting that Clarence could benefit from medication, a strong tranquilizer like Haldol. Clarence stated that back then he was "passive, stupid and weak" and that he knew "something was wrong [with him]".

Medically, documents indicate that he's had a number of maladies in the past, including cardiac difficulties when he was much younger. However, Clarence basically identified the issue of his vision and a persistent cough as salient. He expressed a lot of frustration with the DOC because he has requested cough drops and they have not listened to his concern about his persistent cough that requires frequent use of cough drops as treatment. He expressed resentment at the DOC staff for thinking they know better than he does about the coughing. He also complained of the fact that he is now legally blind after undergoing "four useless operations". He angrily remarked "I can't get shit out of the health unit".

## **FINDINGS**

Clarence was alert and oriented across all spheres. He was capable of providing all of his personal identifying information without hesitation. This includes his height at 5'8" tall and his weight of 145 pounds. He stated that lately he's been losing weight. He attributes this to the normal processing of aging. Clarence presents as an older looking and somewhat frail Native American male [Navajo]. He did not appear to be in any physical distress and offered no complaints of a medical nature other than the persistent cough that requires he be given cough drops. He never coughed during our 70-minute session. He is legally blind, and he ambulates with a cane. I observed how he came in the room and folded the cane as he sat in the chair maintaining very good posture. Hygiene and grooming appeared to be within normal limits. He then described the seriousness of his visual difficulties. He advised me that he wasn't able to really detail what I looked like. He stated that with short distances, say a couple of feet, he could make out his hands, fingers and colors but that is difficult for him to watch TV.

Clarence was very easy to engage. He was immediately cordial and personable. It's evident that his cognitive and memory functioning are intact. He's capable of expressing himself very well. He's likely to be above average intellect. His affect was mildly blunted but generally appropriate. He described his mood as "depressed". He then added "wouldn't you be depressed ( if you were being put to death in a few days)"? He describes having a reactive depression, an adjustment disorder with depressed mood.

With regards to his sleep, he stated that he was "sleeping a lot". He describes hypersomnia. In addition, he stated that he doesn't have much of an appetite. He also has no interest sexually. Clarence denied suicidal ideation. With regards to homicidal ideation or wanting to hurt others, he stated that the only person he would want to hurt badly would be "Donald Trump". Clarence mentioned to this writer that he does follow politics. It's interesting to note that when I asked him about President Biden, he initially blurted out "incompetent". He then modified his response and stated that with regards to President Biden, he would describe him as "a lackluster leader". When I asked about auditory hallucinations, Clarence stated that there are times when he hears his name being called. He described how he heard his name emanating from the side of his head or behind him. He went on to report that he understood that this auditory hallucination was "in [his] head". With regards to visual hallucinations, he stated that sometimes he sees "white squares" and it's annoying because they get in the way of the little vision that he does have when he's watching television. He then revealed that the most frustrating visual hallucination he has pertains to seeing "a little white boy dancing with red and white striped shirt on." He added that this really "pisses [him] off". He explained that he doesn't understand why it has to be a "white boy" that he sees. He would prefer seeing "an Indian boy since I am a Navajo". The hallucinatory experiences he describes appear to be more neurologically than psychiatrically relevant. He responds to the hallucinations with annoyance rather than incorporate them into any kind of a delusional system. He denies ever having had command hallucinations or mood related hallucinations. Interestingly, Clarence himself commented that his hallucinatory experiences may be due to him having "a tumor".

With regards to psychoactive substances, Clarence acknowledges that there was a time back in the late 70's that he had frequent blackouts "about once every two or three weeks" from vodka. He describes having an alcohol dependence. After his incarceration, he learned how to make "hooch" and, years ago, one of the inmates told him that making hooch could be very dangerous and since then he hasn't had any issues regarding the use of psychoactive substances. Notwithstanding, when discussing the issue of the murder conviction Clarence essentially describes having been in an alcoholic blackout because he could not remember what had happened that night.

When it comes to social support system, Clarence reported that he did have a couple of female pen pals. However, he stated that he can't find his address book and he has not been able to keep in touch with these individuals. In addition, he stated that he does have a "spiritual leader" who has been visiting with him since 1986. He stated that his name was Len Foster. It's interesting to know that Clarence initially became rather accusatory of the DOC staff regarding his address book. He began to rant about the fact that the staff had taken his address book and was ascribing malevolent intentions. This went on for a couple of minutes and then Clarence switched gears and stated that perhaps he had misplaced his address book. He remarked needing to do a more thorough search for his address book. This disclosure about the address book is quite revealing when it comes to a Clarence. It shows his tendency to externalize blame to the point that it borders on paranoia but then he recovers. If Clarence's proclivity was to become delusional when suspecting he's been harmed, then one would have expected Clarence to develop and hold on to a position that staff were actively persecuting and tormenting him. He would have contended how this was further evidence of DOC staff targeting him and colluding against him. However, that was not the case at all. Had

he been prone to delusions (as a supposed paranoid schizophrenic) he would've never shifted gears and acknowledge the possibility that perhaps he misplaced the address book.

### **COMPETENCY INQUIRY**

With regards to the incident in 1977 where Clarence "... attacked a girl with a pipe...", Clarence described how he was walking down that side walk and hit her. Asked if the girl reminded him of anyone and he said "no" but he did intimate that there were things going on with him when he assaulted her. I asked him, why did you hit her and essentially he responded that he hit her "because she was there" Asked what he did after he hit her and if he felt bad about hitting her and he said that after he hit her he ran and that he did feel bad about hitting her "... but mostly, I did not want to get caught".

Regarding the DNA and the murder conviction, legally Clarence reiterated that which has been well documented. He assured me it was an illegal conviction and that his DNA was collected by the NAU police and they did not have jurisdiction etc. I focused my inquiry on assessing what transpired and whether he was involved. Clarence initially stated he didn't know the victim but eventually acknowledged that he must have been with her on that fateful night. He stated that he did "not know anything about what went on...I have an idea where it happened...but [only know] what I read in the police report". Were you drunk? "Probably, I was a big drinker at the time..." At that point I tactfully confronted him and suggested that if he had had a blackout as he intimated, that he could have killed her and not remember. Clarence immediately remarked "No, no no [regarding murder], I know I had sex with her". Later he denied having said that he knew he had sex with her. He explained that he didn't remember having sex with her but stated knowing he had sex with her because "my DNA was there" and "...I'm not denying the evidence" In other words, he'll readily accept that he had sex with her even though he does not remember but he does not believe he killed her. Parenthetically, Clarence also made mention that police had DNA from another individual in that case that was ignored and proceeded to engage in the proverbial blaming of the victim as he detailed how the victim was someone who was known to have numerous sexual partners implying others may have had motive. He felt that focusing on him alone was not fair. Despite his lengthy description of the victim's sexual partners, Clarence insisted that he didn't "remember that girl". He went on to explain that had he killed her on purpose then maybe he deserved the death penalty, adding "... but if I was in another state, they wouldn't be killing me..." He then reported being unfortunate because he is here in Arizona and everyone "says we gotta kill him". He indicated knowing "whether [he] did it or not [it] isn't going to change a damn thing. [He] can't bring that girl back... If [he] could [he] would.". Lastly, when Clarence was asked, hypothetically, how he would feel if he were to suddenly have a memory of having killed her and he replied that if he were to recall having murdered that girl, he would have a sense of relief on his way to his execution.

### **CONCLUSION & RECOMMENDATIONS**

After reviewing all the documentation and considering the results of this evaluation, it is evident to this writer that Clarence is primarily suffering from an antisocial personality disorder with salient paranoid and narcissistic personality characteristics. There are a number of references made to Clarence suffering from schizophrenia. However, throughout his imprisonment that spans over 3 decades, he was never treated for a psychotic disorder. At one time when he was younger, he is described as having suffered severe depression. In the past he may have at times experienced episodes of psychosis. However, there is no evidence that Clarence is experiencing active symptoms of schizophrenia at this time. He reports hallucinations that appear to be more neurologically, than psychiatrically relevant. The notion that he is delusional, because of his insistence on errantly applying inapplicable case law to have his murder conviction overturned, is unfounded. There is no doubt that he is deluding himself legally, but this is likely the function of the kind of cognitive distortions that are part and parcel of personality disordered

individual. Clarence wrote numerous motions attempting to suppress the DNA evidence that linked him to the 1978 murder on the basis that the NAU police were not a legal entity when he was arrested in 1985. Clarence, according to documents reviewed misconstrued "the holding in Goode...[that] does not depend on the 1985 amendments. Instead, Goode holds that the board has implicit authority under ARS 15–1626 [A] [2]." Clarence unsuccessfully re-litigated the issue all the way through the Arizona judicial system. The issue however was not deemed "viable" and the Supreme Court denied review. Clarence narcissistically continues to be convinced that his argument is valid and the Courts are mistaken. This is not delusional thinking. The definition of delusional implies an outrageous false belief. In this type of case, a delusional legal defense would sound something like this. "*John Doe maintaining that Intergalactic Law and Statutes supersede and takes precedence over State, National and International law with Jesus Christ as the ultimate judge*". As a result, there is no evidence that Clarence's mental state is so distorted, or his concept of reality so impaired, that he lacks a rational understanding of the State's rationale for his execution. As can be seen in the Competency Inquiry section above, Clarence is so well aware of the State's rationale for his execution that he wishes he resided in a different State, one that did not have the death penalty. He made it clear that he does not want to die and believes that there is nothing to be gained by his execution. He even goes as far as to say that if he could bring the victim back to life, he would. He made it clear that he was "going to fight [his execution] until the end". He has deluded himself into believing that he found case law, that supports his position. He admits that he has worked feverishly for years to write numerous motions and describes his motions as having been sufficiently tenable to have been litigated through Arizona's entire judicial system and turned away at the doorstep of the Supreme Court. Furthermore, Clarence insists that he has no memory of the murder, and this additionally motivates him to fight against being put to death. The notion that he has no memory of the incident surrounding the death of the victim appears to be true since Clarence revealed to this writer that if he were to suddenly remember having killed the victim, he would have a sense of relief at his execution.

Furthermore, Clarence is not suffering from any mental disease or defect, that results in making him unaware that he is to be punished for the crime of murder or unaware that the impending punishment for that crime is death. He is suffering from personality disorder, and this is responsible for his deluded notion that the government has refused to agree with his legal argument, not because his argument is not sound but rather the government is afraid of the consequences of admitting they are wrong. Clarence is well aware of his impending punishment and reported that this is responsible for his current level of depression. He has a moderate adjustment disorder with depressed mood, a reactive depression. He insists that aside from what he considers the illegality of his execution, he finds it is immoral. He wishes he were in another State [sans the death penalty]. He claims that if someone murders another individual in the State of Arizona, that individual can be put to death yet when the US government launches a drone bomb strike to kill a terrorist and ends up killing innocent women and children as well, somehow that's not considered immoral or punishable by law.

Thank you very much for allowing me to consult with you in this matter. If I can be of any further assistance to you in the future, please don't hesitate to contact me.

Respectfully submitted,

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Carlos J. Vega, Psy.D.  
Psychologist

1  
APRIL 30, 2022

CASE NO. 22-135, 22-136, 22-137, 22-138, 22-139

DEAR EXECUTIVE DIRECTOR ELLIOTT:

YOUR APRIL 26 LETTER ARRIVED YESTERDAY.

IN ALL FIVE CASES YOU REMARK THAT THE COMMISSION ON JUDICIAL CONDUCT CANNOT REVIEW THE EVIDENCE IN A CASE OR DETERMINE IF A JUDICIAL OFFICER RULED PROPERLY.

THIS IS COMPLETELY CONTRARY TO THE COMMISSION'S EXISTENCE.

HOW DOES THE COMMISSION ON JUDICIAL CONDUCT DETERMINE IF

A JUDICIAL OFFICER HAS MADE A FAIR AND IMPARTIAL JUDGMENT IN A CASE AS DESCRIBED IN CANON TWO?

WHO DETERMINES OR HOW MANY MEMBERS DETERMINE IN

A CASE WHAT IS FAIR AND IMPARTIAL? WHO IS IMPARTIAL.

2  
AND FAIR' AKIN TO CODIFIED N CANON TWO? HOW DOES  
'RULED PROPERLY' INTERACT JUDICIOUSLY WITH 'IMPARTIAL AND  
FAIR'?

ALTHOUGH MR AND MS LEON TERRY'S EFFORTS TO STOP MR  
EXECUTION MAY BE IN VAIN THE DELIBERATE MIS APPLICATION AND  
IGNORING OF ARIZONA STATUTES AND THE LAW, SPECIFICALLY A.R.S.  
15-1627 (F.G)(F.G), WILL RESULT IN AN EXTRA JUDICIAL  
KILLING THAT WOULD MERIT DISBARMENT ON THOSE WHO ARE  
UNCONCERNED WITH THEIR UNPROFESSIONAL REASON FOR BEING  
EVER AFTER THE TWELFTH HOUR.

BY THE WAY, I WILL NOT PAY THE FERRARI UNTIL I AM  
ACROSS THE OTHER SIDE.

SINCERELY,

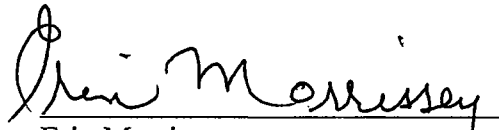
• Clarence W. Dixon, 03/1977

### DECLARATION

I, Erin Morrissey, declare:

1. I am the duly authorized custodian of medical records at Arizona Department of Corrections Rehabilitation & Reentry, and have authority to certify the authenticity of these records.
2. I have caused a diligent search to be conducted under my supervision, and the attached 56 pages are true copies of the Arizona Department of Corrections Rehabilitation & Reentry Medical Records described in the request for the records of Dixon, Clarence, ADCRR #38977, for the time period of 04/22/2022 to 04/25/2022.
3. Based upon my best information and belief, the attached medical records were compiled by the personnel of the Arizona Department of Corrections Rehabilitation & Reentry Health Unit, medical staff, nurses, physicians, or persons acting under their control, in the ordinary course of Health Unit business at or near the time of the events described in the records.
4. In the event any records contained within the attached documents were generated by entities other than the Arizona Department of Corrections Rehabilitation & Reentry, the above-noted custodian of records cannot avow to the accuracy or completeness of records.
5. I declare under penalty of perjury that the foregoing is true and correct.

Dated: 04/25/2022

  
Erin Morrissey  
Medical Records Monitor

Generated: 04/25/2022 10:09 | Offender Name: DIXON, CLARENCE WAYNE | ADC#: 038977

## CHSS001 - Patient Record Synopsis

Name: DIXON, CLARENCE W.

ADC#: 038977

## Patient Description

ADC#: 038977	Inmate Name: DIXON, CLARENCE W.	SSN:
Race/Sex: NA Indian Male	DOB: 08/26/1955	Age: 66 Status: Active
Location: ASPC-E BROWNING D/RW	Bed: WG3G 019B	Custody: Close
Medical Grade: 4		
Admission Date: 01/08/1986	Job Assignment: Unassigned	Earliest Release:

## Current Health Problem/Conditions (1 - 21 of 21)

ID#	Category	Type	National HIE Code(s)	Diagnosis Code	Reaction	Severity	Onset Date	Last Encounter Date
032	Other Diagnosis	Other Diagnosis	SNOMED: 25064002 - Headache (finding) 📄	Headache [R51]			04/12/2022	04/12/2022
031	Other Diagnosis	Other Diagnosis	SNOMED: 60826002 - Coccidioidomycosis (disorder) 📄	Coccidioidomycosis, unspecified [B38.9]			07/22/2021	07/22/2021
030	Mental Health	Mental Health	SNOMED: 48694002 - Anxiety (finding) 📄	Anxiety disorder, unspecified [F41.9]			07/21/2021	07/21/2021
029	Chronic Conditions	Heart Murmur, Rheumatic, etc	SNOMED: 414786004 - Murmur (finding) 📄	Cardiac murmur, unspecified [R01.1]			10/08/2020	02/10/2022
028	Other Diagnosis	Other Diagnosis	SNOMED: 399029005 - Tinea cruris (disorder) 📄	Tinea cruris [B35.6]			04/25/2020	04/25/2020
027	Other Diagnosis	Other Diagnosis	SNOMED: 309529002 - Lung mass (finding) 📄	Other nonspecific abnormal finding of lung field [R91.8]			03/31/2020	03/31/2020
026	Other Diagnosis	Other Diagnosis	SNOMED: 235595009 - Gastroesophageal reflux disease (disorder) 📄	Gastro-esophageal reflux disease without esophagitis [K21.9]			03/17/2020	03/17/2020
025	Other Diagnosis	Pt. Specific Chronic Condition	SNOMED: 61582004 - Allergic rhinitis (disorder) 📄	Other seasonal allergic rhinitis [J30.2]			03/17/2020	03/17/2020
023	Other Diagnosis	Other Diagnosis	SNOMED: 23986001 - Glaucoma (disorder) 📄	Chronic angle-closure glaucoma, bilateral, severe stage [H40.2233]			06/22/2018	06/22/2018
022	Other Diagnosis	Other Diagnosis	SNOMED: 92070006 - 92070006 📄	Benign neoplasm of unspecified cornea [D31.10]			03/09/2017	03/09/2017
021	Other Diagnosis	Other Diagnosis	SNOMED: 69397000 - Angular blepharoconjunctivitis (disorder) 📄	Angular blepharoconjunctivitis, unspecified eye [H10.529]			12/31/2015	12/31/2015
018	Other Diagnosis	Other Diagnosis		Enlarged prostate without lower urinary tract symptoms [N40.0]			10/01/2015	02/10/2015
014	Functional Limitations	Legally Blind		Legal blindness-usa def [369.4]			02/17/2015	02/17/2015
013	Other Diagnosis	Other Diagnosis		Dermatitis NEC [692.89]			02/17/2015	02/17/2015
012	Other Diagnosis	Other Diagnosis		BPH loc w/o ur obs/LUTS [600.20]			02/10/2015	02/10/2015
010	Allergies - Medication	NKDA (No Known Drug Allergies)					12/03/2014	12/03/2014
008	Other Diagnosis	Other Diagnosis		Heart valve replac NEC [V43.3]			12/03/2014	12/03/2014
007	Other Diagnosis	Other Diagnosis		Glaucoma NOS [365.9]			12/03/2014	12/03/2014
005	Other Diagnosis	Other Diagnosis		Prostatitis NOS [601.9]			12/03/2014	12/03/2014
004	Other Diagnosis	Other Diagnosis		Bladder neoplasm NOS [239.4]			12/03/2014	12/03/2014
001	Chronic Conditions	Heart Murmur, Rheumatic, etc					08/15/2014	08/15/2014

## ICD-9/ICD-10 (1 - 57 of 57)

Date	Encounter Type	Staff	ICD	Diagnosis
04/12/2022	Provider - Review	Olmstead, Pamela	R51	Headache
07/22/2021	Provider - Review	Fullmer, Samantha	B38.9	Coccidioidomycosis, unspecified
10/08/2020	Provider - Chronic Care	Kary, Sharon	R01.1	Cardiac murmur, unspecified
04/25/2020	Provider - Chronic Care	Weigel, Natalya	B35.6	Tinea cruris
03/31/2020	Provider - Follow Up Care	Hahn, Betty	R91.8	Other nonspecific abnormal finding of lung field
03/17/2020	Provider - Sick Call - Scheduled	Hahn, Betty	J30.2	Other seasonal allergic rhinitis
03/17/2020	Provider - Sick Call - Scheduled	Hahn, Betty	K21.9	Gastro-esophageal reflux disease without esophagitis
10/30/2019	Provider - Sick Call - Scheduled	Powell, Marianne	R05	Cough
06/22/2018	Provider - Follow Up Care	Penn, Mark	H40.2233	Chronic angle-closure glaucoma, bilateral, severe stage
03/13/2017	Provider - Review	Gay, Maureen	H40.9	Unspecified glaucoma
03/09/2017	Provider - Sick Call - Scheduled	Gay, Maureen	D31.10	Benign neoplasm of unspecified cornea
03/16/2016	Provider - Medication Renewal	Bainbridge, Julie	365.9	Glaucoma NOS
03/16/2016	Provider - Medication Renewal	Bainbridge, Julie	H40.9	Unspecified glaucoma
12/31/2015	Provider - Review	Salter, Nick C	H10.529	Angular blepharoconjunctivitis, unspecified eye
12/11/2015	Provider - Chronic Care	Wilkinson, Xuong	L03.211	Cellulitis of face
09/25/2015	Provider - Medication Renewal	Ruehrup, Jens	365.9	Glaucoma NOS
09/25/2015	Provider - Medication Renewal	Ruehrup, Jens	H40.9	Unspecified glaucoma

Generated: 04/25/2022 10:09 | Offender Name: DIXON, CLARENCE WAYNE | ADC#: 038977

Date	Encounter Type	Staff	ICD	Diagnosis
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	239.4	Bladder neoplasm NOS
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	365.9	Glaucoma NOS
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	369.60	Blindness, one eye
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	595.89	Cystitis NEC
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	599.72	Microscopic hematuria
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	601.9	Prostatitis NOS
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	H40.9	Unspecified glaucoma
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	N41.9	Inflammatory disease of prostate, unspecified
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	V43.3	Heart valve replac NEC
06/01/2015	Provider - Medication Renewal	Jeffrey, Julie R	365.9	Glaucoma NOS
06/01/2015	Provider - Medication Renewal	Jeffrey, Julie R	H40.9	Unspecified glaucoma
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	239.4	Bladder neoplasm NOS
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	365.9	Glaucoma NOS
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	369.60	Blindness, one eye
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	595.89	Cystitis NEC
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	599.72	Microscopic hematuria
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	601.9	Prostatitis NOS
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	H40.9	Unspecified glaucoma
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	N41.9	Inflammatory disease of prostate, unspecified
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	V43.3	Heart valve replac NEC
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	365.9	Glaucoma NOS
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	H40.9	Unspecified glaucoma
02/17/2015	Provider - Sick Call - Unscheduled	Salyer, Nick C	369.4	Legal blindness-usa def
02/17/2015	Provider - Sick Call - Unscheduled	Salyer, Nick C	692.89	Dermatitis NEC
02/17/2015	Provider - Sick Call - Unscheduled	Salyer, Nick C	L25.8	Unspecified contact dermatitis due to other agents
02/10/2015	Provider - Review	Salyer, Nick C	222.2	Benign neoplasm prostate
02/10/2015	Provider - Review	Salyer, Nick C	600.20	BPH loc w/o ur obs/LUTS
02/10/2015	Provider - Review	Salyer, Nick C	D29.1	Benign neoplasm of prostate
02/10/2015	Provider - Review	Salyer, Nick C	N40.0	Enlarged prostate without lower urinary tract symptoms
12/23/2014	Provider - Review	Salyer, Nick C	365.9	Glaucoma NOS
12/23/2014	Provider - Review	Salyer, Nick C	H40.9	Unspecified glaucoma
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	239.4	Bladder neoplasm NOS
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	365.9	Glaucoma NOS
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	369.60	Blindness, one eye
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	595.89	Cystitis NEC
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	599.72	Microscopic hematuria
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	601.9	Prostatitis NOS
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	H40.9	Unspecified glaucoma
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	N41.9	Inflammatory disease of prostate, unspecified
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	V43.3	Heart valve replac NEC

## DSM-IV/DSM-V/ ICD-9/ICD-10 (1 - 1 of 1)

Date	Encounter Type	Staff	Axis	Diagnosis
07/21/2021	MH - Initial Psychiatric Evaluation	Joseph, Adlene, NP		Anxiety disorder, unspecified [F41.9]

## Current Drug Prescriptions (1 - 17 of 17)

Issued	Drug Classification	Dosage	Frequency	Status	Expiration Date
04/12/2022	Acetaminophen Tab (Tylenol)/325MG	2 TABS	BID	Received from Pharmacy	06/10/2022
04/07/2022	Aspirin Chw (Bayer Childrens Aspirin)/81MG	1 tab	QD	Received from Pharmacy	07/06/2022
04/06/2022	Atropine Sul Sol (Isopto Atropine)/1% OP	1gtt	BID	Received from Pharmacy	10/02/2022
04/06/2022	Prednisolone Acetate Suso (Pred Forte)/1% OP	1gtt	TID	Received from Pharmacy	06/04/2022
04/06/2022	Cosopt Pf U/D Sol (Dorzolamide Hcl/Timolol Mal)	1 gtt	BID	Received from Pharmacy	07/04/2022
04/06/2022	Latanoprost Sol (Xalatan)/0.005%	1gtt	QHS	Received from Pharmacy	10/02/2022
04/06/2022	Terazosin Hcl Cap (Hytrin)/2MG	1 CAP	QPM	Received from Pharmacy	10/02/2022
04/06/2022	Acetazolamide Tab (Diamox)/250MG	2 TABS	BID	Received from Pharmacy	07/04/2022
04/07/2022	Aspir-Low Tab (Bayer Low Strength)/81MG EC	1 tab	QD	Discontinued - Other	08/04/2022
03/18/2022	Acetazolamide Tab (Diamox)/250MG	2	BID	Discontinued - Other	05/16/2022
03/07/2022	Terazosin Hcl Cap (Hytrin)/2MG	1	QPM	Discontinued - Other	09/02/2022
03/07/2022	Latanoprost Sol (Xalatan)/0.005%	1gtt	QHS	Discontinued - Other	09/02/2022
02/22/2022	Cosopt Pf U/D Sol (Dorzolamide Hcl/Timolol Mal)	1 gtt	BID	Discontinued - Other	05/22/2022
02/21/2022	Prednisolone Acetate Suso (Pred Forte)/1% OP	1gtt	UAD	Discontinued - Other	04/25/2022
01/17/2022	Fluconazole Tab (Diflucan)/200MG	2 tabs	QD	Discontinued - Other	07/15/2022
12/27/2021	Atropine Sul Sol (Isopto Atropine)/1% OP	1gtt	BID	Discontinued - Other	06/24/2022
12/27/2021	Acetazolamide Tab (Diamox)/125MG	1	QID	Discontinued - Other	06/24/2022

## Current OTC Medications

Type	Begin Date	End Date	Specify Comments
No Rows Found			

## Provider Caseload

Assigned	Staff	Job Title
No Rows Found		

## Latest Encounters (1 - 4 of 4)

Category	Date	Type	Staff	Location
Medical Provider	04/13/2022	Provider - Follow Up Care	Olmstead, Pamela	ASPC-E BROWNING D/RW [A27]
Dental	04/06/2022	Dental - Chart Review	Jeffers, Emilee	ASPC-E BROWNING D/RW [A27]
Mental Health	04/24/2022	MH - Segregation Visit	THOMAS, FELICIA	ASPC-E BROWNING D/RW [A27]
Nursing	04/12/2022	Nurse - Sick Call - Scheduled	Wischhusen, Daphnie	ASPC-E BROWNING D/RW [A27]

## Current Alerts

Generated Date	Type	Due Date	Generated By
No Rows Found			

## Last Vital Signs

Order Date: 04/12/2022	Temperature: 97.6	Pulse: 77	Respiration: 18
BP: 120 / 78	Weight: 125 lb.	Height: 5 ft. 8 in.	
Right: 0			
Corrected Vision: Left: 0			
Both: 0			

## Current Treatment Orders

Category	Type	Approximate Begin Date	Approximate End Date	Status
No Rows Found				

## Key Lab Test Results

Order Date	Specimen Date	Results Date	Type	Result	Value
No Rows Found					

## Current Special Waivers/Diets (1 - 6 of 6)

Started	Type	Expires
04/12/2022	WASTING SYNDROME	04/12/2023
04/06/2022	RUBBER TIPPED CANE	06/30/2022
04/06/2022	LOWER BUNK	06/30/2022
04/06/2022	LOWER TIER	06/30/2022
03/07/2022	Diet - Non-Formulary	03/06/2023
01/14/2022	WASTING SYNDROME	01/14/2023

## Pending Lab Tests

Ordered	Category	Type	Priority
No Rows Found			

## Pending Appointments (1 - 5 of 5)

Scheduled	Type	Location	Staff
08/30/2022	Health Services	ASPC-F-CENTRAL D/RW	Generic, Practitioner
07/25/2022	Health Services	ASPC-F-CENTRAL D/RW	Generic, Practitioner
05/02/2022	Health Services	ASPC-E BROWNING D/RW	Generic, Practitioner
04/25/2022	Health Services	ASPC-E BROWNING D/RW	Generic, Clinic Nurse
02/01/2022	Health Services	ASPC-F-CENTRAL D/RW	Generic, Clinic Nurse

## Current Transfer Holds (1 - 6 of 6)

Placed	Type	Expires
12/01/2021	Medical Hold	05/31/2022
11/23/2021	Medical Hold	02/22/2022
01/24/2020	Medical Hold	01/31/2022
09/21/2017	Medical Hold	09/21/2018
01/11/2016	Medical Hold	07/31/2016
08/02/2010	Medical Hold	10/02/2010

Generated: 04/25/2022 10:09 | Offender Name: DIXON, CLARENCE WAYNE | ADC#: 038977

## CHSS041A - Health Problems/Conditions

Name: DIXON, CLARENCE W.

ADC#: 038977

Show Active Problems/Conditions Only: ☐

## Health Problems/Conditions (1 - 21 of 21)

ID Number	Category	Type	Diagnosis Code	National HIE Code(s)	Status	Status Date
001	Chronic Conditions	Heart Murmur, Rheumatic, etc			Assessed	08/15/2014
004	Other Diagnosis	Other Diagnosis	Bladder neoplasm NOS [239.4]		Assessed	12/03/2014
005	Other Diagnosis	Other Diagnosis	Prostatitis NOS [601.9]		Converted to ICD10	09/30/2015
007	Other Diagnosis	Other Diagnosis	Glaucoma NOS [365.9]		Converted to ICD10	09/30/2015
008	Other Diagnosis	Other Diagnosis	Heart valve replac NEC [V43.3]		Assessed	12/03/2014
010	Allergies - Medication	NKDA (No Known Drug Allergies)			Assessed	12/03/2014
012	Other Diagnosis	Other Diagnosis	BPH loc w/o ur obs/LUTS [600.20]		Converted to ICD10	09/30/2015
013	Other Diagnosis	Other Diagnosis	Dermatitis NEC [692.89]		Converted to ICD10	09/30/2015
014	Functional Limitations	Legally Blind	Legal blindness-usa def [369.4]		Assessed	02/17/2015
018	Other Diagnosis	Other Diagnosis	Enlarged prostate without lower urinary tract symptoms [N40.0]		Assessed	10/01/2015
021	Other Diagnosis	Other Diagnosis	Angular blepharoconjunctivitis, unspecified eye [H10.529]	SNOMED: 69397000 - Angular blepharoconjunctivitis (disorder) 🏠	Assessed	12/31/2015
022	Other Diagnosis	Other Diagnosis	Benign neoplasm of unspecified cornea [D31.10]	SNOMED: 92070006 - 92070006 🏠	Assessed	03/09/2017
023	Other Diagnosis	Other Diagnosis	Chronic angle-closure glaucoma, bilateral, severe stage [H40.2233]	SNOMED: 23986001 - Glaucoma (disorder) 🏠	Assessed	06/22/2018
025	Other Diagnosis	Pt. Specific Chronic Condition	Other seasonal allergic rhinitis [J30.2]	SNOMED: 61582004 - Allergic rhinitis (disorder) 🏠	Assessed	03/17/2020
026	Other Diagnosis	Other Diagnosis	Gastro-esophageal reflux disease without esophagitis [K21.9]	SNOMED: 235595009 - Gastroesophageal reflux disease (disorder) 🏠	Assessed	03/17/2020
027	Other Diagnosis	Other Diagnosis	Other nonspecific abnormal finding of lung field [R91.8]	SNOMED: 309529002 - Lung mass (finding) 🏠	Assessed	03/31/2020
028	Other Diagnosis	Other Diagnosis	Tinea cruris [B35.6]	SNOMED: 399029005 - Tinea cruris (disorder) 🏠	Assessed	04/25/2020
029	Chronic Conditions	Heart Murmur, Rheumatic, etc	Cardiac murmur, unspecified [R01.1]	SNOMED: 414786004 - Murmur (finding) 🏠	Assessed	10/08/2020
030	Mental Health	Mental Health	Anxiety disorder, unspecified [F41.9]	SNOMED: 48694002 - Anxiety (finding) 🏠	Assessed	07/21/2021
031	Other Diagnosis	Other Diagnosis	Coccidioidomycosis, unspecified [B38.9]	SNOMED: 60826002 - Coccidioidomycosis (disorder) 🏠	Assessed	07/22/2021
032	Other Diagnosis	Other Diagnosis	Headache [R51]	SNOMED: 25064002 - Headache (finding) 🏠	Assessed	04/12/2022

# ARIZONA STATE HOSPITAL PSYCHOLOGICAL REPORT

NAME  
BIXON, Clarence W.

K-2

HOSP. NO.  
Moderate Sec. 02-13-10

PSYCHOLOGIST

David L. White, Ed.D.

DATE

October 6, 1977

REASON FOR REFERRAL

Diagnostic interview

TESTS ADMINISTERED

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

## RESULTS

Clarence was interviewed on October 6, 1977. He demonstrates a generally neurotic adjustment with moderate depression being present. He has inflicted injury upon himself only one time in the past, this being when he held a lighted cigarette to the palm of his hand. He reports no suicidal gestures, denies suicidal ideation, but states that he thinks of various ways in which he might be accidentally killed.

On the day he assaulted the girl, he had a fight with his wife and was involved in three different shoving matches with three different men. Marital discord is longstanding. After the assault occurred, Clarence went and sat in his car to wait for the arrival of the police.

Much of this man's poor emotional condition is apparently due to a poor marital situation which he has perceived as being without solution. His guilt and depression are sufficient to cause fantasies about dying, but he does not appear to be the kind of person who will ever die directly by his own hand. He could manage to die "accidentally" or be killed by someone else if his problems are not significantly reduced.

It appears that his depression may have been of psychotic or near-psychotic proportions when he was examined by Dr. Tuchler and Dr. Bendheim in August of 1977.

Diagnosis: Depressive neurosis (300.4)

Recommendations: 1. Individual and marital counseling  
2. Anti-depressant medication at a later date if needed

David L. White, Ed.D.  
DAVID L. WHITE, Ed.D.

000645

DLW:lc  
10/7/77

ER-699

1. LOC. #	2. BEAT #	3. DAY OF WEEK DATE WHEN OCCURRED	4. HOUR OF DAY OFFENSE OCCURRED TO-23 124 HOUR TIME	5. LAST FIRST MIDDLE NAME (FIRM NAME IF BUS)	6. I.R. #
	4A14	SUNDAY	0040H	GUERRA, CHRISTY KAY	77-06700
7. ACTUAL CASH LOSS TO VICTIM	CURRENCY NOTES ETC.			8. ORIGIN SEX DOB	9. TYPE OF REPORT
				M F 6-27-61	AW D.W.
10. TO NEAREST DOLLAR	JEWELRY & PRECIOUS	\$		11. RES. BUS ADD (IF FIRM)	12. DATE & TIME OF THIS REPORT
	METALS	\$		1026 E. SPENCE #205, TEMPE	6-5-77 0820HRS
	FURS	\$		13. EMPLOYER	PHONE #
		\$		JACK N. BOX WEBER & SCOTTSDALE, TEMPE	
14. ITEMIZE PROP. ERTY BELOW	CLOTHING	\$		14. WHO CAN SIGN COMPLAINT FOR CO	ADDRESS
	MISCELLANEOUS	\$			PHONE #
		\$		15. WHO OWNS PROPERTY	ADDRESS
		\$			PHONE #
16. NAME OF BANK OR CREDIT CARD	BRANCH OR CITY			16. DOCTOR WHO TREATED VICTIM	BUS ADDRESS
				DR. GARY GROVE 1500 S. MILL, TEMPE	968-9411
17. PAY TO THE ORDER OF	AMOUNT OF CHECK			17. ADDRESS OF OCCURRENCE	I.R. #
				1026 E. SPENCE, TEMPE	77-06700
18. FIRM NAME ON CHECK	CHECK SERIAL #			18. DATE & TIME OCCURRED	TYPE OF REPORT
				6-5-77 0040HRS	AW D.W.
19. ACCOUNT #	NAME OF MAKER			19. LAST FIRST MIDDLE	ISS. INVESTIGATIVE LEADS
				DIXON, CLARENCE WAYNE	585-84-7126
20. NAME OF PERSON WHO ACCEPTED CK OR DRAFT CAN THEY YES IDENTIFY NO	TOTAL AMOUNT	\$		20. ORIGIN SEX DOB (APPROX)	HEIGHT WEIGHT HAIR EYES COMPLEXION
		\$		I M 8-26-55 5'7 1/2 115 BLK BRN	
21. NUMBER OF CHECKS	DATE WRITTEN			21. ADDRESS	10. ARREST #
				950 S. TERRACE #0-174, TEMPE	54215
22. REASON NOT HONORED	IDENTIFICATION USED			22. EMPLOYER	BUS PHONE #
				UNEMPLOYED	

23. IF VEHICLE INVOLVED	YEAR	MAKE	BODY TYPE	COLOR	LIC #	STATE	IDENTIFYING MARKS	24. WITNESS NAME	ADDRESS	PHONE	EMPLOYER	ADDRESS	PHONE
	64	CHEV	4 DR	TAN	TSG-920	AZ							

17. WITNESS OR INVESTIGATIVE LEADS, PERSONS WHO MAY HAVE COMMITTED OR HAVE KNOWLEDGE OF OFFENSE	NAME	ADDRESS	PHONE #	EMPLOYER	ADDRESS	PHONE #
---	------	---------	---------	----------	---------	---------

M-1) OFFICER D. CLINE #98, TEMPE P.D.

M-2) DR GARY GROVE, TEMPE COMMUNITY HOSPITAL 1500 S. MILL, TEMPE  
968-9411

ON 6-5-77 AT 0045HRS CLARENCE WAYNE DIXON WAS ARRESTED FOR  
ASSAULT WITH A DEADLY WEAPON AFTER STRIKING CHRISTY KAY  
GUERRA WITH A 12"x1" CAST IRON PIPE CAUSING A SEVERE CUT  
ON TOP OF MISS GUERRA'S HEAD WHILE AT 1026 E. SPENCE, TEMPE

000893

25. DID VICTIM RECEIVE A VICTIM'S INFORMATION REPORT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	26. OFFICER WRITING REPORT'S #	BEAT #	DATE & TIME TYPED	DIVN	CLERK'S #	5. I.R. #
	P. Cline #47	4A15	7XCT			77-06700

MISCELLANEOUS COMPLAINT  
126 00126 00126

ER-700

TYPE OF REPORT  
A W O W

LOG-GRID

BEAT #  
HAIN

IR #

77-06700

ON 6-5-77 AT 0041HRS I WAS DISPATCHED TO 1026 E. SPENCE REGARDING UNKNOWN TROUBLE. UPON MY ARRIVAL I CONTACTED CHRISTY GUERRA, VICTIM, WHO WAS SITTING IN THE REAR PARKING LOT OF THE APARTMENT COMPLEX, 1026 E SPENCE, WITH A SEVERE CUT ON TOP OF HER HEAD. MISS GUERRA RELATED THE FOLLOWING.

ON 6-5-77 AT 0035HRS SHE WAS WALKING EAST BOUND ON THE NORTH SIDE OF THE STREET AT 1026 E. SPENCE WHEN A MALE INDIAN WITH LONG BLACK HAIR IN A PONY TAIL APPROACHED HER FROM THE APARTMENT COMPLEX. THE SUBJECT LATER IDENTIFIED AS CLARENCE DIXON STATED "NICE EVENING ISN'T IT" THEN STRUCK HER ON TOP OF HER HEAD WITH AN UNKNOWN OBJECT CAUSING HER TO FALL TO THE GROUND. SHE THEN GOT UP SCREAMING WHICH CAUSED THE SUBJECT TO RUN TO THE REAR OF THE APARTMENT COMPLEX. MISS GUERRA FOLLOWED THE SUBJECT TO THE REAR OF THE COMPLEX AT WHICH TIME I ARRIVED.

I THEN WAS CONTACTED BY OFFICER D. CLINE '98 WHO HAD CLARENCE DIXON IN CUSTODY IN THE PARKING LOT AT THE REAR OF 1026 E. SPENCE. I ESCORTED MISS GUERRA TO OFFICER CLINE'S LOCATION WHERE SHE POSITIVELY IDENTIFIED CLARENCE DIXON AS THE SUBJECT WHO STRUCK HER ON THE HEAD.

CLARENCE DIXON WAS GIVEN HIS RIGHTS PER MIRANDA BY OFFICER CLINE AND TRANSPORTED TO THE TEMPE CITY JAIL (SEE OFFICER CLINE'S SUPPLEMENT)

I THEN CONTACTED DR. GARY GROVE AT TEMPE COMMUNITY HOSPITAL AS TO THE CONDITION OF MISS GUERRA. HE STATED SHE SUFFERED A TWO INCH LACERATION TO THE TOP REAR SECTION OF HER SKULL. REQUIRING THREE SUTURES TO CLOSE THE WOUND.

000894

PRIOR TO LEAVING TO SCENE I OBSERVED

LOG-GRID

BEAT #  
HAIN

IR #

77-06700

CITY OF TEMPE, ARIZONA  
POLICE DEPARTMENT

## CONTINUATION SHEET

Date 6-5-77	Type Occurrence AWOW	Page 3	Of 3	IR Number 77-06700
----------------	-------------------------	-----------	---------	-----------------------

LYING ON THE FRONT SEAT OF CLARENCE DIXON VEHICLE WHICH WAS PARKED AT 1026 E. SPENCE, TEMPE, AZ. A 12" x 1" CAST IRON PIPE WITH A NUT SCREWED ON ONE END OF IT. THE NUT HAD SEVERAL CUTS CUT INTO IT. I SIZED THE PIPE AS EVIDENCE AND PLACED IT IN EVIDENCE LOCKER #13 TEMPE POLICE STATION. THERE WERE NO SIGNS OF PHYSICAL EVIDENCE ON THE PIPE.

I THEN CONTACTED CLARENCE DIXON AT THE TEMPE CITY JAIL WHERE I ADVISED HIM OF HIS RIGHTS PER MIRANDA AND ASKED HIM IF HE UNDERSTOOD THEM WHICH HE REPLIED YES. I THEN ASKED HIM IF HE WOULD ANSWER MY QUESTIONS AND HE STATED YES.

I ASKED CLARENCE DIXON IF HE WANTED TO TELL ME WHAT HAPPENED AT 1026 E. SPENCE. HE STATED THAT HE WALKED UP TO MISS GUERRA AND SAID SOMETHING TO HER THEN STRUCK HER OVER THE HEAD WITH THE PIPE. HE THEN RAN TO HIS VEHICLE WHICH WAS PARKED AT THE REAR OF 1026 E. SPENCE WHEN MISS GUERRA BEGAN TO SCREAM. AT THIS TIME HE THREW THE PIPE INTO HIS VEHICLE.

I SHOWED CLARENCE DIXON THE PIPE I FOUND ON THE FRONT SEAT OF HIS VEHICLE AND ASKED HIM IF HE STRUCK MISS GUERRA WITH IT AND HE REPLIED YES.

CLARENCE DIXON WAS BOOKED INTO TEMPE CITY JAIL FOR ASSAULT WITH A DEADLY WEAPON.

D. C. 747

1. LOC. SAID OF RECOVERY		3. DAY OF WEEK OF RECOVERY		4. HOUR OF DAY OF RECOVERY 0-23		2. BEAT OF RECOVERY		SUPPLEMENTAL REPORT	
18. VALUE OF PROPERTY RECOVERED OR ADDITIONAL PROPERTY TAKEN						7. TYPE OF REPORT AWDW		9. DATE OF THIS SUPPLEMENT 6-5-77	
PROPERTY RECOVERED <input checked="" type="checkbox"/> ADDIT. PROP. TAKEN <input type="checkbox"/>						4. VICTIM'S NAME (IF FIRM NAME IF BUS.) GUERRA, CHEISTY K.		11. LOCATION OF OCCURRENCE 1026 E. SPENCE	
\$ CURRENCY, NOTES ETC.		\$ CLOTHING		Cleared by arrest or exceptionally cleared <input type="checkbox"/>		OVER 18 YEAR OLD <input type="checkbox"/>		UNDER 18 YEAR OLD <input type="checkbox"/>	
\$ JEWELRY, PRECIOUS METALS.		\$ AUTOS		PENDING <input type="checkbox"/>		UNFOUNDED <input type="checkbox"/>		PREVIOUSLY CLEARED BY ARREST OR EXCEPTION <input type="checkbox"/>	
\$ FURS		\$ MISC.		SOC. SEC. #		SEX		DOB (APPROX.) RESIDENCE	
ADDITIONAL SUSP. LAST, FIRST, MIDDLE									
<p>At 0045 ON 6.5.77 I ADVISED THE SUSPECT OF HIS RIGHTS PER MIRANDA TO WHICH HE STATED HE UNDERSTOOD. HE STATED HE DID NOT WISH TO ANSWER ANY QUESTIONS. THE INTERVIEW WAS TERMINATED.</p> <p>I THEN TRANSPORTED THE SUSPECT TO TEMPE P.D. JAIL IN MY VEHICLE. ENROUTE HE ASKED "WHAT DO YOU GET FOR AGGRAVATED ASSAULT." I TOLD HIM I DID NOT KNOW. HE THEN STATED, "IT WAS A STUPID THING TO DO."</p> <p>THE LISTED CONVERSATION WAS UNSOLICITED, AND AFTER ADVISEMENT OF RIGHTS.</p>									
<p>000896</p>									
PAGE # 1		OFFICER WRITING REPORT'S # 98		DATE & TIME TYPED DIVN. CLERK		IR #		77-06700	
CONT'D ON PAGE #		CLERK							

18. VALUE OF PROPERTY RECOVERED OR ADDITIONAL PROPERTY TAKEN		7. TYPE OF REPORT A. W. D. W.	9. DATE OF THIS SUPPLEMENT 6-5-77	5. I.R. # 77-6700
PROPERTY RECOVERED <input type="checkbox"/> ADDIT PROP. TAKEN <input type="checkbox"/>		4. VICTIM'S NAME (PRINT NAME IF MUR.) C. Guerra	11. LOCATION OF OCCURRENCE 1026 E. Spence	
\$ CURRENCY, NOTES ETC.	\$ CLOTHING	Cleared by arrest or exceptionally cleared <input type="checkbox"/>		OVER 18 YEAR OLD <input checked="" type="checkbox"/> UNDER 18 YEAR OLD <input type="checkbox"/>
\$ JEWELRY, PRECIOUS METALS	\$ AUTOS	PENDING <input type="checkbox"/> UNFOUNDED <input type="checkbox"/>		PREVIOUSLY CLEARED BY ARREST OR EXCEPTION <input checked="" type="checkbox"/>
\$ PERS	\$ MISC.			

On this date, I was assigned this case for review and forwarding to the county attorneys office. After reviewing the report I noted that no further follow-up was needed. I checked with the section and learned that she required several stickers to close her wound.

The suspect, Mr. Dixon, was transported to county jail for arraignment.

Records Clerk

Suspect - none CTS  
Victim - none CTS

Pre C/a

000897

77-6700

PAGE 1	DATE & TIME TYPED 62	DIVISION
CITY OF TEMPE, ARIZONA		

POLICE **ER-704**

SUPPLEMENTARY

BRIEF SYNOPSIS OF OCCURRENCE: (Also use this space for additional suspects or victims)

ITEMIZE AND DESCRIBE PROPERTY:

LIST ONLY ONE ITEM PER LINE, NUMBER EACH ITEM ON THE PUZZLE.  
Where possible, place each item in plastic bag, and attach properly tag in inside of bag.

Placed in property Locker 1 12

Date 16 5-77

Time 03:40

OFFICER: D. C. Miller

SERIAL: 4-

PAGE

41

DISPOSITION OF PROPERTY:

PROPERTY  
FROM WHERE:

1. Returned to owner  
2. Destroyed

2. Sold at auction  
3. V.O.T. CHV

5. LHM; M Court  
6. Unable to locate

FOR CUSTODIAN USE ONLY:

REMARKS

REC'D BY

Date \_\_\_\_\_

Time

### Location

Weil 6-6-77 0945



D-3-3

000898

CITY OF TEMPE POLICE DEPARTMENT

PROPERTY INVOICES AND RECEIPT

**ER-705**

10. VALUE OF PROPERTY RECOVERED OR ADDITIONAL PROPERTY TAKEN		1. TYPE OF REPORT <u>AWDW</u>	2. DATE OF THIS SUPPLEMENT <u>6-6-77</u>	3. I.R. # <u>77-6700</u>
PROPERTY RECOVERED <input type="checkbox"/> ADDIT. PROP. TAKEN <input type="checkbox"/>		4. VICTIM'S NAME (FIRM NAME IF BUS.) <u>CHRISTY K. GUERRA</u>	11. LOCATION OF OCCURRENCE <u>1026 E. SPENCE</u>	
5. CURRENCY, NOTES ETC. \$	6. CLOTHING \$	CLEARED BY ARREST OR EXCEPTIONALLY CLEARED <input type="checkbox"/>		OVER 18 YEAR OLD <input type="checkbox"/> UNDER 18 YEAR OLD <input type="checkbox"/>
7. JEWELRY, PRECIOUS METALS, \$	8. AUTOS \$	PENDING <input type="checkbox"/>		UNFOUNDED <input type="checkbox"/> PREVIOUS CLEARED BY ARREST OR EXCEPTION <input type="checkbox"/>
9. FURS \$	10. MISC. \$			

On 6-6-77 at 1400 hours, A/O signed complaint number 61,691 in front of Justice of the Peace MULLENBARK of the Tempe Justice Court, charging CLARENCE WAYNE DIXON with ASSAULT WITH A DEADLY WEAPON.

Warrant Issued ☐

Summons Issued ☐

☒ In Custody

PORTION

PAGE # <u>1</u>	21. OFFICER WRITING REPORT <u>Sgt. [Signature]</u>	22. DATE & TIME TYPED <u>77-6700</u>	DIVN <u>000899</u>	CLERK <u>77-6700</u>
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CITY OF TEMPE, ARIZONA  
POLICE DEPARTMENT

SUPPLEMENTARY

ER-706

1. DATE OF RECOVERY		2. DAY OF WEEK OF RECOVERY		3. HOUR OF DAY OF RECOVERY		4. TYPE OF RECOVERY		5. SUPPLEMENTAL REPORT	
18. VALUE OF PROPERTY RECOVERED OR ADDITIONAL PROPERTY TAKEN				7. TYPE OF REPORT		9. DATE OF THIS SUPPLEMENT		10. IR #	
PROPERTY RECOVERED <input type="checkbox"/> ADDITIONAL PROPERTY TAKEN <input type="checkbox"/>				A.W.D.U.		6.22.77		77-06700	
11. LOCATION OF OCCURRENCE				4. VICTIM'S NAME (FIRM NAME IF A.B.S.)					
1026 E. GRANCE				GUERRA, CHRISTY					
CURRENCY, NOTES ETC.				CLOTHING		Cleared by arrest or exceptionally cleared		OVER 18 YEAR OLD <input type="checkbox"/> UNDER 18 YEAR OLD <input type="checkbox"/>	
JEWELRY, PRECIOUS METALS				AUTOS		PENNING <input type="checkbox"/>		UNFOUNDED <input type="checkbox"/> PREVIOUSLY CLEARED BY ARREST OR EXCEPTION <input type="checkbox"/>	
FURS				MISC.					
ADDITIONAL SUSP. (LAST, FIRST, MIDDLE)				SOC. SEC. #		SEX		DOB (APPROX.) RESIDENCE	
ON 6.22.77 AT CAGUAS I ATTENDED A HEARING FOR CLARENCE									
WAYNE NIXON ON CHARGES OF A.W.D.U. SUBJECT WAS BOUND									
DUE TO SUPERIOR COURT									
PUNCH									
000900									
PAGE #		OFFICER WRITING REPORT'S #		DATE & TIME TYPED		DIVN. CLERK		IR #	
CONT'D ON PAGE #		P. Cues #47		3xet				77-06700	

Temp. Secured	Jailor
G/30	EJ

<p>1. Did the suspect attempt to avoid a frontal attack?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>2. Was the suspect armed at the time of attack?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>3. Was the evidence of this attack found in a suspect's possession?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>4. Did the suspect admit involvement in the attack?</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>5. Did the suspect show any threats in connection with the attack?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>6. Is there any indication that the suspect is an alcoholic, addicted, mentally or physically disturbed?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>7. Is there information to indicate the suspect may have released an heir?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>8. Evidence unobtainable?</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	--

Personal Property #12	Drawer No 6	Signature Doreen W. Dixon	Signature No 100
WALLET + CONTENTS	RINGS		
KEYS	BELT		
GLASSES	AIR GLAZE		
WATCH			Searched by CLINE TH 98
DETAILS OF ARREST			

SEE IR 77-06700

ARREST RECORD

000901

Last Name <b>DEXON</b>		First <b>CLARENE</b>		Middle <b>WAYNE</b>		Personal Property Impounded at Property Room <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		Arrest Number <b>36363</b>	
Residence <b>738 W 5TH ST TEMPE</b>				Occupation <b>GAS STAT. ATTEND</b>		Telephone No. <b>9677011</b>		Alleg. marks & scars <b>SCAR UPPER LEFT ARM</b>	
Sex <b>M</b>	Height <b>58</b>	Weight <b>115</b>	Hair <b>BLK</b>	Eyes <b>BLU</b>	Origin <b>I</b>	Birthdate <b>8-2-55</b>	Age <b>23</b>	Birthplace <b>AZ</b>	Soc. Sec. No. <b>585849186</b>
Location of Arrest <b>WILLIAMS FIELD RD</b>				Grid <b>-</b>	Day <b>MON</b>	Date & Military Time <b>9-18-78 2200 HRS</b>		B.A. Reading <b>/</b>	B.A. Operator # <b>/</b>
Color <b>BEIGE</b>				Year <b>64</b>	Make and Model <b>CHEV 4DR IMPALA</b>		License No. <b>TGS 920</b>	State <b>AZ</b>	Arresting Officers & Serial <b>DET ROGERS SC A. CANNON 46</b>
Disposition of Vehicle <b>SECURED AT SCENE</b>				Driver's License No. <b>FF 872X</b>		State <b>AZ</b>		Officer's Court Dates & Time <b>1 56 2 46</b>	
Code # <b>13-279</b>		Complaint <b>A.W.D.W</b>		Warrant # <b>13-371</b>		Code # <b>96110</b>		Complaint <b>13-322</b>	
Written Description of Charge <b>A.W.D.W</b>		Written Description of Charge <b>D.P.</b>		Written Description of Charge <b>BURGLARY 1st</b>		Written Description of Charge <b>BURGLARY 1st</b>		Written Description of Charge <b>BURGLARY 1st</b>	
I.D. Unit <b>DCP</b>								Time Booked <b>2362</b>	
All "YES" answers require an explanation in the details of arrest.								Jailer <b>000</b>	

1. Did the suspect attempt to avoid or resist arrest? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	5. Did the suspect make any threats in connection with the offense? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. Was the suspect armed at the time of arrest? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6. Is there any indication that the suspect is an alcoholic, addict, mentally or physically disturbed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3. Was the evidence of this offense found in the suspect's possession? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	7. Is there information to indicate the suspect may flee if released on bail? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Did the suspect admit involvement in the offense? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	8. Evidence impounded? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Personal Property: <b>5.01</b>	Drawn No.: <b>2</b>	Signature in: <i>Clarence W. Dixon</i>	Signature out: <i>Dip K. [Signature]</i>
<b>WALLET + CONTENTS</b>		<b>2 NUTS + WASHERS</b>	
<b>1- BECT</b>		<b>GLASSES</b>	
<b>1- AZ DRIVERS LIC.</b>		<b>CARD W/ CONTENTS</b>	
<b>1- PEN</b>		Searched by: <b>CANNON 46</b>	

DETAILS OF ARREST: **SEE TIR'S 78-11825 + 78-11824 78-11924**

*WCC - neg*  
*2V*  
*Cards*  
*1K for just Ct*

963-7777

TEST RECORD

2360 000902

# Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

## Key Features That Define the Psychotic Disorders

### Delusions

*Delusions* are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, grandiose). *Persecutory delusions* (i.e., belief that one is going to be harmed, harassed, and so forth by an individual, organization, or other group) are most common. *Referential delusions* (i.e., belief that certain gestures, comments, environmental cues, and so forth are directed at oneself) are also common. *Grandiose delusions* (i.e., when an individual believes that he or she has exceptional abilities, wealth, or fame) and *erotomanic delusions* (i.e., when an individual believes falsely that another person is in love with him or her) are also seen. *Nihilistic delusions* involve the conviction that a major catastrophe will occur, and *somatic delusions* focus on preoccupations regarding health and organ function.

Delusions are deemed *bizarre* if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences. An example of a bizarre delusion is the belief that an outside force has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars. An example of a nonbizarre delusion is the belief that one is under surveillance by the police, despite a lack of convincing evidence. Delusions that express a loss of control over mind or body are generally considered to be bizarre; these include the belief that one's thoughts have been "removed" by some outside force (*thought withdrawal*), that alien thoughts have been put into one's mind (*thought insertion*), or that one's body or actions are being acted on or manipulated by some outside force (*delusions of control*). The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity.

### Hallucinations

*Hallucinations* are perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control. They may occur in any sensory modality, but auditory hallucinations are the most common in schizophrenia and related disorders. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the individual's own thoughts. The hallucinations must occur in the context of a clear sensorium; those that occur while falling asleep (*hypnagogic*) or waking up

(*hypnopompic*) are considered to be within the range of normal experience. Hallucinations may be a normal part of religious experience in certain cultural contexts.

## Disorganized Thinking (Speech)

*Disorganized thinking (formal thought disorder)* is typically inferred from the individual's speech. The individual may switch from one topic to another (*derailment* or *loose associations*). Answers to questions may be obliquely related or completely unrelated (*tangentiality*). Rarely, speech may be so severely disorganized that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganization (*incoherence* or "word salad"). Because mildly disorganized speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication. The severity of the impairment may be difficult to evaluate if the person making the diagnosis comes from a different linguistic background than that of the person being examined. Less severe disorganized thinking or speech may occur during the prodromal and residual periods of schizophrenia.

## Grossly Disorganized or Abnormal Motor Behavior (Including Catatonia)

*Grossly disorganized or abnormal motor behavior* may manifest itself in a variety of ways, ranging from childlike "silliness" to unpredictable agitation. Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living.

*Catatonic behavior* is a marked decrease in reactivity to the environment. This ranges from resistance to instructions (*negativism*); to maintaining a rigid, inappropriate or bizarre posture; to a complete lack of verbal and motor responses (*mutism* and *stupor*). It can also include purposeless and excessive motor activity without obvious cause (*catatonic excitement*). Other features are repeated stereotyped movements, staring, grimacing, mutism, and the echoing of speech. Although catatonia has historically been associated with schizophrenia, catatonic symptoms are nonspecific and may occur in other mental disorders (e.g., bipolar or depressive disorders with catatonia) and in medical conditions (catatonic disorder due to another medical condition).

## Negative Symptoms

*Negative symptoms* account for a substantial portion of the morbidity associated with schizophrenia but are less prominent in other psychotic disorders. Two negative symptoms are particularly prominent in schizophrenia: diminished emotional expression and avolition. *Diminished emotional expression* includes reductions in the expression of emotions in the face, eye contact, intonation of speech (prosody), and movements of the hand, head, and face that normally give an emotional emphasis to speech. *Avolition* is a decrease in motivated self-initiated purposeful activities. The individual may sit for long periods of time and show little interest in participating in work or social activities. Other negative symptoms include alogia, anhedonia, and asociality. *Alogia* is manifested by diminished speech output. *Anhedonia* is the decreased ability to experience pleasure from positive stimuli or a degradation in the recollection of pleasure previously experienced. *Asociality* refers to the apparent lack of interest in social interactions and may be associated with avolition, but it can also be a manifestation of limited opportunities for social interactions.

## Disorders in This Chapter

This chapter is organized along a gradient of psychopathology. Clinicians should first consider conditions that do not reach full criteria for a psychotic disorder or are limited to one

domain of psychopathology. Then they should consider time-limited conditions. Finally, the diagnosis of a schizophrenia spectrum disorder requires the exclusion of another condition that may give rise to psychosis.

Schizotypal personality disorder is noted within this chapter as it is considered within the schizophrenia spectrum, although its full description is found in the chapter “Personality Disorders.” The diagnosis schizotypal personality disorder captures a pervasive pattern of social and interpersonal deficits, including reduced capacity for close relationships; cognitive or perceptual distortions; and eccentricities of behavior, usually beginning by early adulthood but in some cases first becoming apparent in childhood and adolescence. Abnormalities of beliefs, thinking, and perception are below the threshold for the diagnosis of a psychotic disorder.

Two conditions are defined by abnormalities limited to one domain of psychosis: delusions or catatonia. Delusional disorder is characterized by at least 1 month of delusions but no other psychotic symptoms. Catatonia is described later in the chapter and further in this discussion.

Brief psychotic disorder lasts more than 1 day and remits by 1 month. Schizophreniform disorder is characterized by a symptomatic presentation equivalent to that of schizophrenia except for its duration (less than 6 months) and the absence of a requirement for a decline in functioning.

Schizophrenia lasts for at least 6 months and includes at least 1 month of active-phase symptoms. In schizoaffective disorder, a mood episode and the active-phase symptoms of schizophrenia occur together and were preceded or are followed by at least 2 weeks of delusions or hallucinations without prominent mood symptoms.

Psychotic disorders may be induced by another condition. In substance/medication-induced psychotic disorder, the psychotic symptoms are judged to be a physiological consequence of a drug of abuse, a medication, or toxin exposure and cease after removal of the agent. In psychotic disorder due to another medical condition, the psychotic symptoms are judged to be a direct physiological consequence of another medical condition.

Catatonia can occur in several disorders, including neurodevelopmental, psychotic, bipolar, depressive, and other mental disorders. This chapter also includes the diagnoses catatonia associated with another mental disorder (catatonia specifier), catatonic disorder due to another medical condition, and unspecified catatonia, and the diagnostic criteria for all three conditions are described together.

Other specified and unspecified schizophrenia spectrum and other psychotic disorders are included for classifying psychotic presentations that do not meet the criteria for any of the specific psychotic disorders, or psychotic symptomatology about which there is inadequate or contradictory information.

## Clinician-Rated Assessment of Symptoms and Related Clinical Phenomena in Psychosis

Psychotic disorders are heterogeneous, and the severity of symptoms can predict important aspects of the illness, such as the degree of cognitive or neurobiological deficits. To move the field forward, a detailed framework for the assessment of severity is included in Section III “Assessment Measures,” which may help with treatment planning, prognostic decision making, and research on pathophysiological mechanisms. Section III “Assessment Measures” also contains dimensional assessments of the primary symptoms of psychosis, including hallucinations, delusions, disorganized speech (except for substance/medication-induced psychotic disorder and psychotic disorder due to another medical condition), abnormal psychomotor behavior, and negative symptoms, as well as dimensional assessments of depression and mania. The severity of mood symptoms in psychosis has prognostic value and guides treatment. There is growing evidence that schizoaffective

## Unmet Need for Mental Health Care in Schizophrenia: An Overview of Literature and New Data From a First-Admission Study

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We present an overview of the literature on the patterns of mental health service use and the unmet need for care in individuals with schizophrenia with a focus on studies in the United States. We also present new data on the longitudinal course of treatments from a study of first-admission patients with schizophrenia. In epidemiological surveys, approximately 40% of the respondents with schizophrenia report that they have not received any mental health treatments in the preceding 6–12 months. Clinical epidemiological studies also find that many patients virtually drop out of treatment after their index contact with services and receive little mental health care in subsequent years. Clinical studies of patients in routine treatment settings indicate that the treatment patterns of these patients often fall short of the benchmarks set by evidence-based practice guidelines, while at least half of these patients continue to experience significant symptoms. The divergence from the guidelines is more pronounced with regard to psychosocial than medication treatments and in outpatient than in inpatient settings. The expansion of managed care has led to further reduction in the use of psychosocial treatments and, in some settings, continuity of care. In conclusion, we found a substantial level of unmet need for care among individuals with schizophrenia both at community level and in treatment settings. More than half of the individuals with this often chronic and disabling condition receive either no treatment or suboptimal treatment. Recovery in this patient population cannot be fully achieved without enhancing access to services and improving the quality of available services. The recent expansion of managed care has made this goal more difficult to achieve.

**Key words:** unmet need for care/treatment patterns/mental health services

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### Introduction

This article presents an overview of the literature on patterns of mental health service use and, by extension, the unmet need for care in individuals with schizophrenia. In addition, new data on the longitudinal course of treatments in a first-admission sample of patients with schizophrenia are presented. Randomized clinical trials have repeatedly shown the efficacy of pharmacological and psychosocial interventions in the management of schizophrenia.<sup>1,2</sup> Findings from these studies have been synthesized into practice guidelines with the aim of improving the treatment of schizophrenia across various settings.<sup>3–8</sup> However, treatments offered in routine clinical practice often fall short of guideline recommendations, and many patients in the community receive no or little treatment.<sup>9–18</sup> Thus, our knowledge of evidence-based treatment practices does not always translate into better care and outcomes for patients.

In comparison to hundreds of randomized clinical trials of various pharmacological and psychosocial treatments for schizophrenia, there are relatively few studies of the treatment patterns in routine care settings and the extent and the correlates of the unmet treatment needs in this patient population. Furthermore, much of the available data focus on patterns of pharmacotherapy, and less is known about the patterns of use of psychosocial treatments.

From a public health perspective, the issue of unmet need for care can be defined at different levels (eg, the community and the services) or from different perspectives (eg, the patients, their families, or their clinicians). Furthermore, there is currently a debate about the threshold at which care would be essential, and the lack of care would constitute an unmet need.<sup>19</sup> For example, it is not clear whether treatment would be needed for the large number of people in community-based epidemiological studies who meet the full diagnostic criteria for a mood or anxiety disorder but who do not seek treatment.<sup>20–22</sup> Some authors have argued that many of these individuals experience “appropriate homeostatic responses that are neither pathologic nor in need of treatment.”<sup>20</sup>(p114) These debates are likely less relevant to schizophrenia, in which the duration of illness, the severity of symptoms, and the social and occupational dysfunction that are the defining

characteristics of the disorder<sup>23</sup> justify treatment in almost all individuals with the diagnosis.

In both community and service settings, unmet needs are often evaluated by examining the patterns of service use and by comparing these patterns with the treatments recommended by evidence-based practice guidelines. An alternative approach would be to directly assess the perceptions of consumers, family members, or clinicians of the extent of met and unmet needs.

At the level of services, unmet needs commonly result from the discontinuities in treatment or provision of substandard treatments due to inadequate resources, prohibitive cost of treatments, inadequate health insurance, changes in insurance coverage, or the lack of satisfaction with the available treatments. These factors often coexist and may act synergistically in interfering with treatment.

In this article, we will present an overview of some of the studies that have evaluated the unmet need for treatment in schizophrenia. We will approach the question of unmet need for treatment according to 3 definitions as (a) the prevalence of cases of disorder that have not received any treatment in community settings or patients who have dropped out of treatment in representative clinical samples, (b) the prevalence of inadequate treatment or treatment of low quality in routine clinical settings, and (c) the prevalence of self-rated unmet need for treatment as perceived by the patients. For assessing the extent of unmet need for treatment based on the first 2 definitions, we will rely on studies of treatment patterns among individuals who meet the criteria for schizophrenia in general population epidemiological surveys or in clinical epidemiological studies that are based on representative clinical samples drawn from delimited geographical regions and clinical sample of patients drawn from routine treatment settings. We will also present data on the longitudinal course of mental health treatments in patients with schizophrenia from the Suffolk County Mental Health Project—a clinical epidemiological study of first-admission psychotic disorders in Long Island, New York. To assess the prevalence of unmet need for treatment as perceived by patients, we will briefly examine the growing literature on patient-perceived needs. Discussing these studies in concert highlights the various limitations and strengths of each approach as well as the complexities of assessing the unmet needs for care in schizophrenia. Our overview focuses on studies from the United States. However, where appropriate or in cases where there are few US studies, we will also discuss studies conducted in other countries.

## Treatment Patterns

### *Treatment Patterns in Population Samples*

Much of our current knowledge about treatment patterns in individuals with common mood and anxiety disorders

comes from the epidemiological surveys of general populations.<sup>24,25</sup> Fewer epidemiological studies of general populations have investigated the treatment patterns in representative samples of individuals with schizophrenia. In a 1980 review of the literature on the rates of mental health treatment in epidemiological studies, Link and Dohrenwend<sup>18</sup> identified 7 studies from across the world conducted between 1938 and 1973 that specifically examined the lifetime treatment rates for schizophrenia. The median rate of lifetime treatment in these studies was 83.3% (range: 50%–100%) as compared with the general population studies of overall psychopathology (mostly mood, anxiety, and alcohol disorders) in which the median rate of treatment was only 26.7% (range: 7.8%–52.0%). Comparison across these studies, however, is hampered by the sociocultural variations in the samples, variations in case ascertainment methodology, and diagnostic criteria.

The introduction of explicit diagnostic criteria such as the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition) (*DSM-III*) and the incorporation of these diagnostic criteria into structured interview instruments paved the way for a second generation of epidemiological studies, which use standardized assessments and generally have large and representative population-based samples.<sup>26</sup> In the United States, the Epidemiologic Catchment Area (ECA) study is the earliest and the best known of the second-generation studies that specifically focused on *DSM-III* disorders, including schizophrenia.<sup>27</sup> The ECA was conducted in the early 1980s and sampled over 20 000 adults from 5 sampling sites across the United States. One advantage of the ECA over subsequent epidemiological studies was that in addition to the household samples, individuals in institutions were also sampled. The ECA found that about 1.3% of the population met lifetime *DSM-III* criteria for schizophrenia based on the lay-administered Diagnostic Interview Schedule.<sup>27</sup> Another 0.2% met criteria for the schizophreniform disorder. The large majority of these cases were identified in the community as opposed to an institutional setting.<sup>27</sup> The ECA found that among individuals with symptoms in the past 6 months (6-mo schizophrenia), only 57% had received some form of outpatient mental health care in this period: 40% from the specialty mental health sector (psychiatrists, psychologists, social worker, or other mental health professionals) and 17% from the general medical sector or the human services (such as the clergy or non-mental health social work).<sup>27</sup> The ECA study did not report the lifetime history of treatment in this group of patients. However, the 57% rate of 6-month treatment seeking is much smaller than the 83% lifetime treatment from earlier epidemiological studies. It is not clear whether changes in the time and the diagnostic criteria or differences in the time frame (6 mo vs lifetime), in sociocultural characteristics of the samples, or in the

ascertainment methods (structured interview vs clinician evaluation) accounted for this difference.

The second landmark US epidemiological survey, the National Comorbidity Survey (NCS), was conducted a decade later, between 1990 and 1992. The NCS included a nationally representative sample of individuals between the ages 15 and 54 years and administered the University of Michigan revised version of the Composite International Diagnostic Interview (CIDI). This study found a similar lifetime prevalence of the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition Revised) schizophrenia and schizophreniform disorder to that from the ECA (1.3%).<sup>28</sup> However, the NCS also reported prevalence estimates based on the clinical reinterviews with the NCS respondents who had been assigned a diagnosis of schizophrenia or schizophreniform disorder by the lay-administered structured interview. The concordance between the structured interview and the interviews by the senior clinicians was quite low, with only 10% of the reinterviewed subjects being assigned a diagnosis of schizophrenia or schizophreniform disorder and 37% receiving a broader diagnosis of “nonaffective psychoses.” By the clinician diagnosis, the lifetime prevalence rates were 0.2% for schizophrenia or schizophreniform disorders and 0.3% for nonaffective psychoses—much lower than the estimates from the structured interviews. Among the clinician-identified cases of nonaffective psychoses symptomatic in the past 12 months, 57.9% had used some form of mental health services in that time frame: 47.5% had used specialty mental health services, 21.5% general medical services, 16.3% human services, and 22.0% self-help resources.<sup>29</sup>

A further wave of the NCS, the US National Comorbidity Survey-Replication (NCS-R), was conducted a decade later, between 2001 and 2003. The NCS-R sampled adults aged 18 years and older and administered a revised version of the CIDI. It also used a significantly modified ascertainment scheme to minimize false-positive responses<sup>30</sup> as well as the statistical method of multiple imputation,<sup>31</sup> commonly used to estimate missing data, to estimate the predicted prevalence of the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) clinician-diagnosed nonaffective psychoses based on the responses to the structured interviews. The lifetime prevalence of the probable nonaffective psychoses (including schizophrenia, schizophreniform disorder, as well as the other nonaffective psychoses) was 1.5% based on the structured interviews and 0.5% based on the predicted clinician diagnoses.<sup>30</sup> We note that the 0.5% prevalence rate is consistent with the estimates from the other epidemiological studies.<sup>32</sup>

Among the NCS-R cases with a predicted clinician diagnosis of nonaffective psychosis who had active symptoms in the past 12 months, 57.8% reported mental health treatment contacts in the same 12-month period: 49.8% were treated in the mental health specialty sector, 5.0% in

the general medical sector, 11.9% in the human services sector, and 13.4% in the complementary-alternative medicine sector.<sup>30</sup>

The differences in the sampling frame, the age ranges, the diagnostic criteria, the interview instruments, and the ascertainment methods make comparisons across these 3 US surveys very difficult.<sup>20</sup> The difficulty is compounded by the inaccuracies inherent in estimating the prevalence of rare conditions in population samples<sup>33</sup> that are likely responsible for the discrepancy in prevalence rates based on the lay-administered interviews and the clinician interviews.

The probability of correctly identifying cases of a disorder based on a screen-positive result (positive predictive validity) and of the cases free of the disorder based on a screen-negative result (negative predictive validity) is significantly affected by the true prevalence of the disorder, as well as by the sensitivity and specificity of the screening test. Eaton et al<sup>33</sup> estimated that, eg, in a population survey of 1000 persons with a true prevalence of schizophrenia of 1%, a measure having 90% sensitivity and specificity (far higher than the sensitivity of currently available structured interview instruments) would identify 9 true cases and 99 false-positive cases, generating a prevalence estimate of more than 10% or 10 times higher than the true prevalence of the disorder.

Thus, the majority of the cases of schizophrenia identified using a lay-administered interview would be false-positive cases. Unless true cases of a disorder in a population can be identified with some accuracy, the patterns of treatment for that disorder cannot be accurately determined. Furthermore, the prevalence estimates of rare disorders are particularly sensitive to the selective nonresponse,<sup>25</sup> and there is some evidence that individuals with schizophrenia in the community are less likely than other individuals to respond to surveys or appear in population-based samples if they are living in nursing homes and other quasi-institutional community settings.<sup>34</sup>

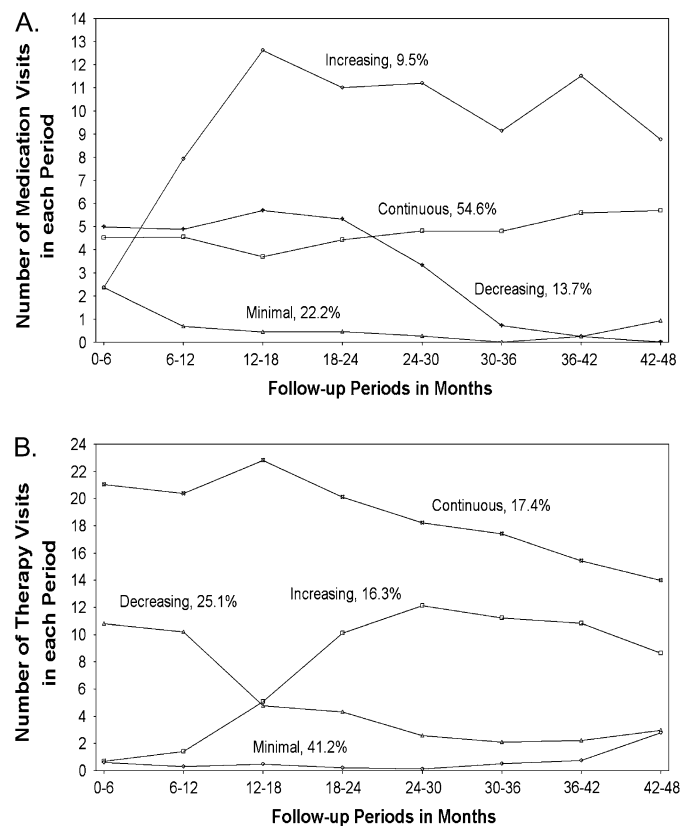
Despite these limitations, the similarity in treatment patterns of individuals with schizophrenia across the 3 population surveys is remarkable. About 57%–58% of individuals with active symptoms of schizophrenia in the 6–12 months prior to interview reported receiving some form of mental health treatment in that time frame. In the NCS and the NCS-R, between 47.5% and 49.8% received treatment in the specialty mental health sector. **Thus, based on these data, at least 40% of individuals with actively symptomatic schizophrenia-spectrum disorders living in community settings in the United States have no consistent contact with needed services, and more than half have no contact with the specialty mental health treatment sector.** These numbers reflect a large degree of potential unmet need for treatment among individuals with schizophrenia living in the various US communities.

*Treatment Patterns in Clinical Epidemiological Samples*

Whereas general population epidemiological surveys have typically been the gold standard for estimating the burden of the unmet need for treatment in the population,<sup>24</sup> the limitations in ascertaining cases of rare disorders, noted earlier, constrain their usefulness for assessing the degree of unmet need for treatment in schizophrenia. Furthermore, many seriously ill individuals are likely underrepresented in these surveys because they live in the institutional settings or because they are homeless or incarcerated. Finally, epidemiological surveys generally collect limited information about the specific content and course of the treatments, such as history of recent hospitalizations and outpatient visits and the current use of medications. A thorough assessment of the psychiatric treatment history would require more detailed information on the content and course of treatments.

Epidemiological studies of clinical populations have an advantage over general population epidemiological surveys in that they typically collect more detailed information on the content and course of treatments in patients recruited from clinical settings in a well-defined geographical region.<sup>11,35–39</sup> The ascertainment of cases in some of these studies is quite exhaustive, approximating that of general population surveys.<sup>36</sup> When compared with clinical studies, epidemiological studies of clinical samples also provide a less biased picture of the use of clinical services and the extent of unmet need for care. This is especially true of the longitudinal studies involving first-contact or first-admission patients<sup>36,37</sup> in which the frequent and infrequent users of services are equally likely to be included. In contrast, in studies of current patients in routine clinical settings, the probability of being sampled is proportional to the volume of service use, leading to what Cohen and Cohen labeled the “clinician’s illusion.”<sup>40</sup> Thus, longitudinal studies of first-contact or first-admission patients offer a more balanced view of the patterns of service use and the unmet needs for care than is possible when drawing from cross-sectional clinical samples.

For example, the report of Jablensky *et al.*<sup>36</sup> based on the follow-up data from the World Health Organization (WHO) 10-country study identified subgroups of patients with psychotic disorders who had considerable gaps in their care. Furthermore, the treatment patterns varied significantly across the settings. Only 15.9% of the patients in the developing countries (Colombia, India, and Nigeria) were on antipsychotic medications for more than 75% of the follow-up period, compared with 60.8% in the industrialized countries (Czech Republic, Denmark, Ireland, Japan, Russia, United Kingdom, and United States). Similarly, 55.5% of the patients in the developing countries were never hospitalized during the follow-up period compared with 8.1% in the industrialized countries.<sup>32</sup> These



**Fig. 1.** Trajectories of Medication Visits (A) and Therapy Visits (B) in Patients With a Diagnosis of Schizophrenia in the Suffolk County Mental Health Project.

numbers reflect considerable variation across the industrialized and the developing countries in the patterns of service use and the unmet need for care that would not be identified in studies involving clinical samples as the patients with less use of services in clinical samples would not be equally represented as the frequent users.

As another example, in a clinical epidemiological study of first-admission psychotic disorders from the private and public inpatient facilities in the Suffolk County, NY,<sup>14,37,41</sup> we were able to use the latent growth class methodology<sup>42–44</sup> to identify subgroups of schizophrenia patients according to their use of services in the 4-year period after their first admission.<sup>42,44</sup> Groups were defined based on their longitudinal patterns (or trajectories) of medication and psychotherapy (individual, group, and family therapy combined) visits assessed at 6-month intervals (figure 1A and 1B).

In this study, which took place in a semiurban area of Long Island, only 54.6% of the 172 first-admission patients with a consensus diagnosis of schizophrenia based on 2 years of observation had continuous medication visits in the 4 years following first admission (ie, 3–6 visits per 6 mo throughout the 4-y follow-up) and only 17.4% had continuous psychotherapy visits (ie, 12–24 visits per 6 mo). In contrast, 22.2% had minimal medication

visits in the follow-up (ie, consistently less than 3 visits per 6 mo), and 41.2% had minimal therapy visits (ie, consistently less than 6 visits per 6 mo) (figure 1A and 1B). Overall, 12.8% of the sample fell in both the minimum medication and therapy visits and 16.3% in both the continuous medication and therapy visit classes.

Medication visits were strongly associated with being on psychiatric medications at each time point. For example, at the 6-month follow-up, 85.7% of the participants with continuous medication visits were taking any psychiatric medications compared with 44.4% of those with minimal medication visits ( $\chi^2_{df=1}=21.94$ ,  $P < .001$ ). Similarly, 90.0% of those with continuous medication visits and 39.4% with minimal medication visits were taking any psychiatric medications at the 24-month follow-up ( $\chi^2_{df=1}=34.32$ ,  $P < .001$ ).

The majority of the patients in the minimal medication visits and minimal psychotherapy visits remained in need of treatment through most of the first 4-year period after the index admission. Almost half of these patients were rated as continuously ill on the WHO Course of Illness Scale<sup>36</sup> at the 4-year follow-up and as many were rated as having marked deterioration on the Schedule for Affective Disorders and Schizophrenia<sup>45</sup> (tables 1 and 2). Furthermore, large percentages of patients in minimal medication or psychotherapy visit groups suffered from multiple episodes of illness with incomplete remission between episodes (45.7% in the minimal medications group and 50.0% in the minimal psychotherapy group). Very few of the patients with minimal contact with services remained in full remission after the first episode of illness (tables 1 and 2).

Patients with minimal medication visits were more likely than those with continuous medication visits to have multiple hospitalizations during the first 4 years (34.2% vs 21.3%,  $P = .045$ ). However, they were less likely to remain consistently in treatment between the 4- and 10-year follow-ups or to be on any psychiatric medications at the 10-year follow-up (table 1).

Compared with patients with continuous psychotherapy visits in the first 4 years, those with minimal psychotherapy visits were more likely to be continuously ill during the first 4 years and between the 4- and 10-year follow-ups (47.0% vs 24.1% in the first 4 y and 72.4% vs 51.7% between the 4 and 10 y). However, these differences were only at a statistical trend level and did not reach a statistically significant level. Patients with continuous psychotherapy visits in the first 4 years were significantly more likely to be receiving any psychotherapy at the 10-year follow-up (table 2).

Another example that shows the utility of clinical epidemiological studies is the Australian Study of Low Prevalence Disorders.<sup>11</sup> In that study, Jablensky et al used a 2-phase survey of all the individuals with psychotic disorders who made a contact with the public mental health services in 4 urban or predominantly urban areas

in Australia in the late 1990s.<sup>11</sup> In the second phase of the study, relatively detailed interviews were conducted with a stratified random sample of the individuals screened in the first phase of the survey. In addition, the authors surveyed individuals with psychotic disorders who received care from general medical professionals or psychiatrists in private practice; homeless individuals identified at night shelters, hostels, or other “safety net” services in the community; and individuals with a history of contact with services in the past 3 years but no current contact who were identified from the service registries.<sup>46</sup> Among the patients thus identified, only 59.6% had used any outpatient services in the past 12 months and 43.6% had used inpatient services.<sup>47</sup> A total of 21.9% reported that they had used no psychiatric services in this period.

The nonusers of services generally had lower levels of symptomatology and were twice as likely as the current users to have a course of illness characterized by a single episode of psychotic illness followed by recovery and 3 times less likely to have a course of illness characterized by severe deterioration.<sup>11</sup> The nonusers were also less likely to have a comorbid substance use disorder and to have a history of self-harm behavior, arrests, and/or victimization.<sup>11</sup> These variations echo earlier research in other settings<sup>48</sup> indicating that in heterogeneous samples of patients with various psychotic disorders service use and the needs for care vary considerably among different subgroups of patients. However, these results are at variance with those from the homogeneous prospectively followed sample of patients with a diagnosis of schizophrenia from the Suffolk County Mental Health Project, discussed earlier, in which the course of illness in the minimal treatment group was characterized by continuous illness or significant residual symptoms.

In summary, clinical epidemiological studies address some of the deficiencies of the general population epidemiological surveys by using patient samples, thus reducing the false-positive rate, and by incorporating more detailed information on the nature and the volume of service use. Furthermore, studies of first-contact or first-admission patients, such as the Suffolk County Mental Health Project<sup>41</sup> or the WHO 10-country study,<sup>36</sup> and studies using patient registries to identify the previous users of services, such as in the Australian Study of Low Prevalence Disorders,<sup>11</sup> can identify subgroups of patients who use fewer services or drop out of treatment—patients who are not well represented in cross-sectional clinical samples (see below).

Nevertheless, clinical epidemiological studies tend to be labor intensive and expensive. As a result, relatively few recent clinical epidemiological studies of psychotic disorders are available, and much of our knowledge about the patterns and the quality of treatments in schizophrenia patients comes from nonepidemiological, cross-sectional studies of chronically ill, clinical samples.

**Table 1.** Outcomes at 4 and 10 y According to Medication Visit Trajectories in First-Admission Patients With a Research Diagnosis of Schizophrenia in the Suffolk County Mental Health Project

Variable	Medication Visit Trajectories								Comparisons, Test <sub>df</sub> , <i>P</i>	
	Continuous ( <i>N</i> = 94)		Increasing ( <i>N</i> = 16)		Decreasing ( <i>N</i> = 24)		Minimal ( <i>N</i> = 38)			
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	All Groups	Continuous Vs Minimal
Outcomes, 4 y										
SADS rating of functioning <sup>45,a</sup>										
Return to highest premorbid level	13	15.3	0	0.0	3	13.6	3	9.7	$\chi^2_6 = 9.01, .173$	$\chi^2_2 = 0.81, .668$
Any residual impairment	37	43.5	3	20.0	7	31.8	13	41.9		
Marked deterioration	35	41.2	12	80.0	12	54.6	15	48.4		
WHO rating of course of illness <sup>36,b</sup>										
Single psychotic episode + full remission	1	1.1	0	0.0	0	0.0	1	2.9	$\chi^2_6 = 6.90, .330$	$\chi^2_2 = 3.55, .169$
Multiple episodes or incomplete remission	58	65.2	7	46.7	11	47.8	16	45.7		
Continuous illness	30	33.7	8	53.3	12	52.2	17	48.6		
Number of rehospitalizations <sup>c</sup>										
0	33	35.1	5	31.3	13	54.2	17	44.7	$\chi^2_6 = 11.7, .070$	$\chi^2_2 = 6.18, .045^*$
1	41	43.6	9	56.3	8	33.3	8	21.1		
2+	20	21.3	2	12.5	3	12.5	13	34.2		
Outcomes, 10 y										
SADS rating of functioning <sup>45,d</sup>										
Return to highest premorbid level	2	2.6	1	7.1	0	0.0	3	10.0	$\chi^2_6 = 6.00, .424$	$\chi^2_2 = 3.15, .207$
Any residual impairment	28	35.9	3	21.4	8	44.4	8	26.7		
Marked deterioration	48	61.5	10	71.4	10	55.6	19	63.3		
WHO rating of course of illness <sup>36,e</sup>										
Single psychotic episode + full remission	0	0.0	0	0.0	0	0.0	0	0.0	$\chi^2_3 = 1.31, .726$	$\chi^2_2 = 1.19, .275$
Multiple episodes or incomplete remission	27	34.2	5	35.7	6	33.3	7	23.3		
Continuous illness	52	65.8	9	64.3	12	66.7	23	76.7		
Number of rehospitalizations <sup>f</sup>										
0	41	54.0	8	57.1	8	47.1	14	51.9	$\chi^2_6 = 1.70, .945$	$\chi^2_2 = 0.36, .834$
1	8	10.5	2	14.3	3	17.7	2	7.4		
2+	27	35.5	4	28.6	6	35.3	11	40.7		
Percent of time in treatment between 4- and 10-y follow-ups <sup>g</sup>										
0	0	0.0	0	0.0	1	5.9	3	12.5	$\chi^2_9 = 15.87, .070$	$\chi^2_3 = 11.71, .008^{**}$
1 to <50	3	4.4	1	8.3	1	5.9	3	12.5		
50 to <100	16	23.2	1	8.3	6	35.3	3	12.5		
100	50	74.5	10	83.3	9	52.9	15	62.5		
Medication use at 10-y follow-up <sup>h</sup>										
Any	68	91.9	14	100	16	88.9	19	76.0	$\chi^2_3 = 6.84, .077$	$\chi^2_1 = 4.43, .035^*$
None	6	8.1	0	0.0	2	11.1	6	24.0		

Note: SADS, Schedule for Affective Disorders and Schizophrenia; WHO, World Health Organization.

<sup>a</sup>*N* = 153.

<sup>b</sup>*N* = 162.

<sup>c</sup>*N* = 172.

<sup>d</sup>*N* = 140.

<sup>e</sup>*N* = 141.

<sup>f</sup>*N* = 134.

<sup>g</sup>*N* = 122.

<sup>h</sup>*N* = 131.

\**P* < .05, \*\**P* < .01.

### Treatment Patterns in Clinical Samples

Over the years, a number of studies have examined patterns of treatment in clinical samples of patients with schizophrenia.<sup>9,10,12,15–17,49–64</sup> Differences in the time period, chronicity of the patient populations, treatment settings, and assessment methods make comparison across these

studies difficult. Nevertheless, a common theme that emerges from many of these studies is the inadequate quality of treatments provided in routine treatment settings.

A number of studies have compared the treatment patterns in routine treatment settings against the evidence-based practice guideline benchmarks.<sup>9,12,17,49,53,55,64</sup>

**Table 2.** Outcomes at 4 and 10 y According to Therapy Visit Trajectories in First-Admission Patients With a Research Diagnosis of Schizophrenia in the Suffolk County Mental Health Project

Variable	Therapy Visit Trajectories								Comparisons, Test <sub>df</sub> , <i>P</i>	
	Continuous ( <i>N</i> = 94)		Increasing ( <i>N</i> = 16)		Decreasing ( <i>N</i> = 24)		Minimal ( <i>N</i> = 38)			
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	All Groups	Continuous Vs Minimal
Outcomes, 4 y										
SADS rating of functioning <sup>45,a</sup>										
Return to highest premorbid level	5	18.5	3	12.0	4	10.3	7	11.3	$\chi^2_6 = 2.81, .832$	$\chi^2_2 = 2.14, .342$
Any residual impairment	12	44.4	9	36.0	17	43.6	22	35.5		
Marked deterioration	10	37.0	13	52.0	18	46.2	33	53.2		
WHO rating of course of illness <sup>36,b</sup>										
Single psychotic episode + full remission	0	0.0	0	0.0	1	2.6	1	1.5	$\chi^2_6 = 6.65, .354$	$\chi^2_2 = 5.36, .069$
Multiple episodes or incomplete remission	22	75.9	16	57.1	21	53.9	33	50.0		
Continuous illness	7	24.1	12	42.9	17	43.6	31	47.0		
Number of rehospitalizations <sup>c</sup>										
0	14	46.7	9	32.1	19	44.2	26	36.6	$\chi^2_6 = 8.14, .228$	$\chi^2_2 = 1.95, .377$
1	11	36.7	16	57.1	15	34.9	24	33.8		
2+	5	16.7	3	10.7	9	20.9	21	29.6		
Outcomes, 10 y										
SADS rating of functioning <sup>45,d</sup>										
Return to highest premorbid level	3	10.7	0	0.0	1	2.9	2	3.5	$\chi^2_6 = 8.09, .232$	$\chi^2_2 = 4.62, .099$
Any residual impairment	13	46.4	5	25.0	11	32.4	18	31.0		
Marked deterioration	12	42.9	15	75.0	22	64.7	38	65.5		
WHO rating of course of illness <sup>36,e</sup>										
Single psychotic episode + full remission	0	0.0	0	0.0	0	0.0	0	0.0	$\chi^2_3 = 4.61, .203$	$\chi^2_2 = 3.66, .056$
Multiple episodes or incomplete remission	14	48.3	5	25.0	10	29.4	16	27.6		
Continuous illness	15	51.7	15	75.0	24	70.6	42	72.4		
Number of rehospitalizations <sup>f</sup>										
0	17	58.6	12	60.0	17	53.1	25	47.2	$\chi^2_6 = 3.79, .705$	$\chi^2_2 = 1.07, .587$
1	4	13.8	1	5.0	2	6.3	8	15.1		
2+	8	27.6	7	35.0	13	40.6	20	37.7		
Percent of time in treatment between 4- and 10-y follow-ups <sup>g</sup>										
0	0	0.0	0	0.0	1	3.3	3	6.3	$\chi^2_9 = 9.41, .400$	$\chi^2_3 = 3.98, .264$
1 to <50	0	0.0	1	5.6	4	13.3	3	6.3		
50 to <100	6	23.1	5	27.8	8	26.7	7	14.6		
100	20	76.9	12	66.7	17	56.7	35	72.9		
Psychotherapy visits in the last 6 mo of the 10-y follow-up <sup>h</sup>										
Any visits	22	75.9	12	63.2	18	56.3	25	47.2	$\chi^2_3 = 6.59, .086$	$\chi^2_1 = 6.31, .012^*$
None	7	24.1	7	36.8	14	43.8	28	52.8		

Note: SADS, Schedule for Affective Disorders and Schizophrenia; WHO, World Health Organization.

<sup>a</sup>*N* = 153.

<sup>b</sup>*N* = 162.

<sup>c</sup>*N* = 172.

<sup>d</sup>*N* = 140.

<sup>e</sup>*N* = 141.

<sup>f</sup>*N* = 134.

<sup>g</sup>*N* = 122.

<sup>h</sup>*N* = 133.

\**P* < .05.

However, again the diversity of practice guidelines and the differences in operationalization of the benchmarks limit comparison across these studies.<sup>58,65</sup> Nevertheless, some of these studies used the Schizophrenia Patient Outcome Research Team (PORT) benchmarks.<sup>9,12,49,66</sup> The results of 4 such studies are summarized in table

3. The PORT benchmarks set evidence-based quality indicators for pharmacological as well as psychosocial treatments of schizophrenia in inpatient and outpatient settings. The PORT guidelines were first published in 1998<sup>8</sup> and were subsequently revised in 2004.<sup>67</sup> All studies in table 3 used the 1998 PORT guidelines.

**Table 3.** Percent of Participants With Schizophrenia in Clinical Studies Who Are Receiving Treatments That Are Conformant With the PORT Treatment Recommendations

PORT Recommendations	Lehman et al <sup>12</sup>		West et al <sup>49</sup>	Dickey et al <sup>9</sup>		Busch et al <sup>66</sup>	
	Inpatient (%)	Outpatient (%)		Inpatient (%)	Outpatient (%)	Outpatient Managed Care (%)	Outpatient Fee for Service <sup>a</sup> (%)
Inpatient antipsychotic treatment	89.2	— <sup>b</sup>	— <sup>c</sup>	86.2–86.7	— <sup>b</sup>	— <sup>b</sup>	— <sup>b</sup>
Appropriate dose of inpatient antipsychotics	62.4	— <sup>b</sup>	— <sup>c</sup>	59.3–69.2	— <sup>b</sup>	— <sup>b</sup>	— <sup>b</sup>
Maintenance antipsychotic treatment	— <sup>b</sup>	92.3	99 <sup>c</sup>	— <sup>b</sup>	92.9–95.1	88.3	86.2–87.6
Appropriate dose of maintenance antipsychotics	— <sup>b</sup>	29.1	83 <sup>c</sup>	— <sup>b</sup>	34.1–45.0 <sup>e</sup>	— <sup>d</sup>	— <sup>d</sup>
Anti-Parkinson treatment	53.9	46.1	51	— <sup>d</sup>	— <sup>d</sup>	4.8	4.9–5.6
Depot medication	50.0	35.0	30	— <sup>d</sup>	— <sup>d</sup>	— <sup>d</sup>	— <sup>d</sup>
Adjunctive depression medications	32.2	45.7	38–100 <sup>f</sup>	— <sup>d</sup>	— <sup>d</sup>	— <sup>d</sup>	— <sup>d</sup>
Adjunctive anxiety medications	33.3	41.3	45	— <sup>d</sup>	— <sup>d</sup>	— <sup>d</sup>	— <sup>d</sup>
Adjunctive psychosis medications	22.9	14.4	— <sup>d</sup>	— <sup>d</sup>	— <sup>d</sup>	— <sup>d</sup>	— <sup>d</sup>
Any psychotherapy	96.5	45.0	69	90.0–98.9 <sup>g</sup>	79.2–81.2 <sup>g</sup>	20.3 <sup>h</sup>	36.9–71.6 <sup>h</sup>
Family therapy	31.6	9.6	— <sup>d</sup>	30.0–53.2 <sup>i</sup>	— <sup>d</sup>	0.05	0.2–0.6
Vocational rehabilitation	30.4	22.5	0	— <sup>d</sup>	20.4–23.2	— <sup>d</sup>	— <sup>d</sup>
Case management	8.6 <sup>j</sup>	10.1 <sup>j</sup>	38	31.9–38.3	43.4–64.0 <sup>k</sup>	— <sup>d</sup>	— <sup>d</sup>

Note: PORT, Patient Outcome Research Team.

<sup>a</sup>Includes patients in carve-out region before transition to the carve-out plan and patients in comparison regions before and after transition.

<sup>b</sup>Not relevant.

<sup>c</sup>The study did not report separate values for inpatients and outpatients.

<sup>d</sup>Not reported.

<sup>e</sup>Mean standardized monthly dose within PORT-recommended range.

<sup>f</sup>All the patients with a diagnosis of major depression received antidepressants, but only 38% of those with “moderate to severe” depressive symptoms did so.

<sup>g</sup>Any psychosocial treatment.

<sup>h</sup>Individual therapy and/or group therapy.

<sup>i</sup>Any family contact.

<sup>j</sup>Assertive community treatment and assertive case management were included.

<sup>k</sup>Case management was reported only in high-risk patients (ie, patients with a history of hospitalization in the past 6 mo).

The PORT group’s study is perhaps the best-known research assessing the conformance of the treatment patterns in routine care settings with the evidence-based recommendations.<sup>12</sup> The study examined treatment patterns in a random sample of over 700 individuals with a clinical diagnosis of schizophrenia recruited from routine care settings in a southern and a midwestern state between 1994 and 1997. The patients were sampled from inpatient units and outpatient clinics in private and public institutions, including the Veteran’s Administration facilities. The sampling sites included rural as well as urban sites.<sup>12</sup> The data collected by surveying the patients and abstracting the inpatient and outpatient medical records showed

a modest level of conformance with nearly all evidence-based recommendations, except for any prescription of antipsychotic medications, for which there was a high conformance (table 3). For most recommendations, fewer than half of the patients received guideline-conformant treatment. Furthermore, conformance was generally poorer for the outpatient treatments than for the inpatient treatments and for psychosocial treatments than for medications.<sup>12</sup>

Similar findings were reported in the 1999 American Psychiatric Association Practice Research Network (PRN) study, which used a nationally representative group of psychiatrists to obtain information about a sample of

their patients and the treatments they received.<sup>49</sup> Of the 151 patients with a clinical diagnosis of schizophrenia identified in this study, 99% received antipsychotic medications. However, 37% of these patients had difficulty adhering to medications, and 64% suffered from moderate to severe psychotic symptoms, likely partly due to poor adherence. Only 42% of the patients received any psychotherapy and 69% any form of psychosocial intervention, including case management.<sup>49</sup> The rates of conformance with the practice guideline recommendations for the psychosocial treatments ranged from 0% to 43% and were especially lower among the patients with public insurance.

The variation across the studies in table 3 can be attributable to a number of factors including differences in the composition of samples, method of assessing conformance, and differences in the definitions used. For example, the study by Lehman et al<sup>12</sup> examined conformance with PORT guidelines in patients in public mental health facilities in 2 states using chart reviews, whereas the study by West et al<sup>49</sup> used a sample of patients from practices of psychiatrists who volunteered to participate in the American Psychiatric Association PRN study, and the data provided by these psychiatrists were not independently verified. As another example, Dickey et al<sup>9</sup> categorized any family contact as family therapy, whereas in Busch et al<sup>66</sup> study family therapy was more stringently defined based on coded claims data. These differences make direct comparison of estimates in table 3 difficult. Furthermore, the definitions of psychotherapy and vocational rehabilitation in these and other studies of quality of treatments in routine clinical settings are often very broad and overinclusive. Thus, these studies likely overestimate the rates of conformance with evidence-based guidelines with regard to these treatments. Nevertheless, it is noteworthy that even with the broad and overinclusive definitions the rates of conformance in these studies are consistently low (table 3).

A few studies have investigated the impact of contextual and service-level characteristics on treatment patterns.<sup>9,17,51</sup> For example, Young et al<sup>17</sup> examined the treatment patterns of 224 outpatients with schizophrenia recruited from 2 publicly funded clinics: an outpatient Veterans Administration (VA) clinic and a Community Mental Health Center (CMHC) clinic. The authors found significant differences in the treatment patterns between the 2 settings. More patients in the VA clinic compared with the CMHC clinic received poor quality medication management of their symptoms and side effects (44% vs 31%). Even after excluding patients who had characteristics that contributed to poor treatment quality (such as poor adherence or substance use disorders), the difference between the settings persisted. However, the schizophrenia patients with severe disability in the CMHC clinic were somewhat more likely to receive poor quality case management than those in the VA clinic.<sup>17</sup>

A reanalysis of the PORT study data by Rosenheck et al<sup>51</sup> mainly confirmed the results of the Young et al<sup>17</sup> study by finding greater conformance with the PORT guidelines in the non-VA settings compared with the VA settings of the PORT study. Patients in the non-VA outpatient settings were more likely than their VA counterparts to be taking at least one antipsychotic medication, to be on a depot medication if they had trouble with compliance, or to be receiving work therapy or job training and were less likely to be receiving a dose greater than 600 mg equivalent of chlorpromazine. Patients in the non-VA inpatient settings were also more likely to be offered individual or group therapy or assertive community treatment. However, these patients were more likely than their VA counterparts to be on a dose smaller than 300 mg chlorpromazine equivalent.<sup>51</sup>

In summary, studies comparing treatment patterns in routine treatment settings have mostly found that conformance is poorer for psychosocial treatments than for medications treatments, for outpatient settings than for inpatient settings, and in the VA than in the non-VA facilities. When contrasted with the relatively high-conformance rates with medication treatment benchmarks, the modest conformance rates for vocational rehabilitation and family therapy suggest that the main focus of treatments in many services is on management of symptoms rather than on rehabilitation and improvement of social and occupational functioning.

### *Correlates of Treatment Patterns*

A large number of clinical studies have specifically examined the impact of clinical and sociodemographic characteristics on treatment patterns in general and on adherence with medication treatments in particular.<sup>68,69</sup> Lack of insight, cognitive problems, comorbid substance use disorders, minority racial status, and younger age have all been associated with poorer adherence with treatment.<sup>16,68–71</sup> Whereas the use of depot medications<sup>68</sup> and various psychosocial interventions<sup>2,72</sup> have been shown to improve adherence with medication treatments, the use of both remains limited (table 1). Lack of efficacy and bothersome side effects remain the major reasons for medication nonadherence in most cases.<sup>1</sup>

### *The Impact of Managed Care*

The majority of studies reviewed above were based on data from the 1990s. However, since then, there have been significant changes in the structure and the content of services for patients with severe mental disorders in the United States, most importantly due to expansion of managed care plans. Findings with regard to patterns of treatment under managed care payment arrangements have been mixed.<sup>37,65,66,73,74</sup> One study of 420 Medicaid beneficiaries in Massachusetts found no differences between patients enrolled in a capitated managed care plan and those in

a fee-for-service program with regard to patterns of medication use or the use of psychosocial treatments.<sup>9</sup>

In another study of Medicaid enrollees, the introduction of a carve-out arrangement led to a reduction in the proportion of patients with schizophrenia who received any form of psychosocial treatment, including individual or group psychotherapy or psychosocial rehabilitation. No changes were observed in the area of medication management (eg, likelihood of receiving any antipsychotic medication, receiving second-generation antipsychotics, management of side effects). The authors attributed these changes in the receipt of psychosocial treatments to the fact that managed care carve outs were at financial risk for providing these treatments but not for providing medications.<sup>66</sup>

Similar findings were reported in other settings. For example, results from a Medicaid program in 2 counties in Florida between 1994 and 2000 revealed no meaningful changes in the percentage of patients with schizophrenia who had used antipsychotic medications: 86.2% in 1994–1995 vs 89.8% in 1999–2000.<sup>73</sup> In contrast, in the same time span, the use of individual and/or group therapy decreased from 52.4% to 30.4%, and the rate of psychosocial rehabilitation decreased from 47.6% to 39.7. Less than 1% of the patients received family therapy across the years.<sup>73</sup> A later study based on a sample of patients in the Florida Medicaid program found that the care of patients in a prepaid mental health program and a Health Maintenance Organization was much less likely to conform to the American Psychiatric Association's practice guidelines, mainly due to the low conformance with psychotherapy guidelines.<sup>75</sup>

Another study found a significant increase in the discontinuity of antipsychotic medications after transition to the mental health carve-out arrangement in the Tennessee Medicaid program.<sup>74</sup> The study used administrative data on over 8000 patients in 2 cohorts enrolled in the Medicaid program, one cohort preceded the introduction of the carve-out plan and the other immediately followed it. Among patients for whom continuity of treatment was deemed “essential” based on their history, 29% in the posttransition cohort compared with 20% in the pretransition cohort experienced discontinuity of over 60 days in medication treatment.<sup>74</sup> This study did not examine changes in the use of psychosocial treatments.

Finally, a study examining the prior authorization regulation for the use of atypical antipsychotic medications implemented in the Maine Medicaid program in 2003 also found increased psychiatric medication discontinuity and switching of medications.<sup>76</sup> The Maine program was discontinued in 2004, but as the authors note, many other Medicaid managed care programs across the United States require preauthorization for the costlier antipsychotic medications.<sup>76</sup>

The introduction of the new Medicare Part D insurance may have created new complexities in the care of patients with schizophrenia as this insurance plan includes a cap on

spending. There is some evidence that patients with severe mental disorders are at increased risk of discontinuities in medication treatment when faced with gaps in medication insurance coverage such as those imposed by spending caps.<sup>77</sup> The effects of the Part D insurance in this patient population have yet to be fully appreciated.

In summary, managed care arrangements have had variable effects across different settings but are typically associated with reduced use of psychosocial treatments.<sup>71,73,75,78</sup> Furthermore, in some, but not all settings, managed care arrangements appear to be associated with increased discontinuity in treatment.<sup>37,74,78,79</sup>

### *Unmet Need for Other Services*

Patients with schizophrenia often face unmet needs for many other services beyond the traditional mental health services. There has been a renewed interest in the medical care of these patients, including receipt of the needed preventive and treatment services for chronic medical conditions and dental care.<sup>80,81</sup> There is also a growing body of literature pointing to the lower quality of the medical services in patients with schizophrenia and other severe mental disorders,<sup>82–84</sup> as well as a widening mortality gap between these patients and the general population.<sup>85</sup>

The widespread use of the atypical or second-generation antipsychotic medications has further contributed to the medical problems of patients with schizophrenia as some of these medications are associated with significant weight gain and an increased risk of hyperglycemia and hyperlipidemia.<sup>1</sup> Nevertheless, the need for proper monitoring of these metabolic parameters and interventions to reduce the risk of future comorbidities often remains unmet. In one study of Medicaid patients who were started on an atypical antipsychotic medication, only 19% received baseline glucose testing and 6% received baseline lipid testing.<sup>86</sup> The rates increased modestly between 1998 and 2003.<sup>86</sup> In another study of patients in 3 VA clinics between 2002 and 2004, 46.2% had a weight problem.<sup>87</sup> In almost none was the weight problem appropriately managed. As another example, a recent study of smokers with type 2 diabetes found that individuals with schizophrenia in this sample were significantly less likely than their counterparts without a serious mental illness to receive preventive treatments such as regular blood pressure examinations, lipid profiles, or treatment with angiotensin converting enzyme inhibitors or statins.<sup>88</sup>

The high prevalence of medical problems in patients with schizophrenia also calls for integration or better coordination of mental health and general medical services.<sup>89</sup> However, coordination between various services for this patient group and other patients with severe mental disorders is often inadequate.<sup>90</sup> For example, in a study of the Massachusetts Medicaid beneficiaries, contact between the mental health and the outpatient primary care providers was noted in only 43%–50% of

the inpatients and 22.1%–24.2% of the outpatients with schizophrenia.<sup>9</sup>

Another mostly unmet service need in this patient population that also calls for integration of services or coordination across services is the need for substance abuse treatment.<sup>90</sup> Drug and alcohol disorders are commonly comorbid with schizophrenia. For example, in the National Institute of Mental Health Clinical Antipsychotic Trials of Intervention Effectiveness, about 60% of schizophrenia patients were found to use substances and 37% met criteria for a current substance use disorder.<sup>91</sup> Furthermore, these disorders have significant implications for the management and the social and clinical outcomes of schizophrenia.<sup>91–94</sup> Nevertheless, in many of these patients, substance disorders go untreated. In one study, only about half of the schizophrenia patients with a need for substance abuse treatment received such care.<sup>9</sup> The traditional separation between mental health and substance abuse services further contributes to the problem of unmet need for substance abuse treatment in this patient population. The recognition that substance comorbidity in this population is the norm rather than an exception and that addressing one problem without the other is inefficient has led to a number of recent attempts at implementation of integrated programs.<sup>95,96</sup> Dual diagnosis programs are also now available in many substance disorder treatment facilities, although the range of services needed by dual diagnosis patients is not available in all these programs.<sup>97</sup>

Many schizophrenia patients smoke.<sup>98–100</sup> A meta-analysis of over 40 studies from across the world found both a greater risk of current smoking (odds ratio [OR] = 5.3, 95% confidence interval [CI] = 4.9–5.7) and a lower likelihood of smoking cessation (OR = 0.46, 95% CI = 0.23–0.69) in patients with schizophrenia.<sup>98</sup> The estimated prevalence of smoking in schizophrenia patients in this meta-analysis was 62%,<sup>98</sup> attesting to the unmet need for management of smoking in this patient population.

Meeting the patients' multiple needs for medical care and substance abuse treatment is especially difficult for practitioners working in solo practices or in small, single specialty group practices. For these practitioners, the solution to this problem calls for establishing more meaningful links and better coordination with other providers or agencies. The growing use of information technology can potentially facilitate such coordination.<sup>101,102</sup> However, psychiatry has been slow in adopting information technology.<sup>103</sup>

Better integration of individuals with schizophrenia in the community would ultimately depend on their ability to attain meaningful social roles, including useful employment that can provide a sense of mastery and self-worth. Due to the disabling nature of the illness, many individuals with schizophrenia would need extra support and guidance beyond traditional vocational counseling to find and maintain useful employment. There is a growing

body of literature indicating that supported employment produces better results than conventional vocational training or other interventions in this patient population.<sup>104–107</sup> Dissemination of these practices in the VA system has produced modest but promising results.<sup>108–110</sup>

Finally, many patients with schizophrenia are at increased risk of homelessness and associated adverse social and health outcomes, such as victimization and sexually transmitted diseases.<sup>91,111–116</sup> These patients often need the help of a case manager to negotiate the elaborate maze of social service organizations and to obtain housing and other needed social services.<sup>117</sup> However, as data reviewed earlier suggest (table 3), only a minority of patients in need of case management receive such service.

### Patients' Perceived Unmet Need for Care

The studies reviewed above underscore the deficiencies in the treatment of schizophrenia by examining the patterns of service use in routine treatment settings and, in some cases, by comparing these patterns with the evidence-based practice guideline recommendations for the treatment of schizophrenia. Another perspective on the problem of unmet need for care in this patient population is the patients' perceptions of the nature and extent of their met and unmet needs.<sup>118–124</sup> This direct approach to assessing needs is in keeping with current trends toward shared decision making in the care of patients with severe mental disorders and reflects the diversity of the needs in this patient population.<sup>125–127</sup>

Over the years, a number of instruments have been developed to assess the patients' perceptions of their needs.<sup>122–124</sup> Perhaps, the most widely used of these measures is the Camberwell Assessment of Needs (CAN) instrument that asks questions regarding the perceived met and unmet needs of the patients in areas ranging from the management of psychotic symptoms to the need for food, child-care, and transportation. Studies comparing patient and staff reports of met and unmet needs in these areas have identified some consistencies.<sup>119,123</sup> However, the studies have also identified differences between the patient and staff views, especially with regard to unmet needs. For example, in a Nordic study of schizophrenia patients, the most prevalent patient-identified unmet needs were in the domains of company, intimate relationships, and psychological distress; whereas, psychotic symptoms and daytime activities were among the top-rated areas of unmet need by the staff.<sup>119</sup> Furthermore, the small number of patient-reported unmet needs in these studies is surprising given the wide gaps in the quality of treatment in routine treatment settings. For example, out of the 22 possible unmet needs on the CAN instrument, the patients and caregivers in the Nordic study identified on average about 2 unmet needs.<sup>119</sup> The differences in the patient and staff views, as well as between the unmet needs identified in the epidemiological and

the clinical studies on the one hand and the patients' perceptions of unmet needs on the other hand, highlight the complexities inherent in defining needs and, by extension, in defining the unmet needs in this patient population.<sup>122</sup>

A number of factors likely contribute to the differences in results of need assessment using these different approaches and perspectives. Many patients with schizophrenia may not fully appreciate the extent of their mental health problems and their mental health-care needs.<sup>128,129</sup> Furthermore, individuals vary in their needs and responses to treatments, whereas evidence-based standards provide universal benchmarks based on the needs and treatment responses of a typical patient. Finally, perceptions of need naturally differ between different stakeholders, and no one perspective can be said to be necessarily more accurate or true than another. Rather, these differences in the patient and provider perspectives may present opportunities to involve patients and families as well as other stakeholders in the treatment planning process.<sup>130,131</sup>

## Conclusion

The preceding overview of the literature on patterns of treatment in schizophrenia and the extent of the unmet need for care reveals considerable gaps in our current knowledge. First, there is a paucity of reliable data from population-based epidemiological studies in the United States on which to base the population estimates of treatment and the potential unmet need for treatment. As noted earlier, difficulties inherent in the assessment of rare disorders severely limit our ability to accurately identify individuals with schizophrenia in ongoing epidemiological surveys of general populations using lay-administered interview instruments.<sup>33</sup> Without accurate identification of the cases, establishing treatment patterns and the extent of the unmet need for care in these surveys is not feasible. Multistage survey methods<sup>132</sup> or clinician-augmented surveys<sup>30</sup> improve upon such classification, but they typically incur considerable additional costs and are not always implemented. Furthermore, these methods cannot resolve the problem of selective nonresponse and undersampling of individuals who are homeless, incarcerated, or living in quasi-institutional community settings.<sup>30</sup>

Nevertheless, the available data from the major US population surveys suggest that approximately 40% of individuals in the community with schizophrenia remain out of care either consistently or at least for long periods of time while experiencing significant symptoms. Clinical epidemiological studies address some of the limitations of general population surveys by reducing the false-positive rate and by using more detailed assessments.<sup>11,36,41</sup> These studies also indicate that a significant percentage of patients remain consistently out of treatment after their initial contact with services. In the Suffolk County Mental Health Project, eg, 20% of patients with a diagnosis of

schizophrenia remained consistently out of medication treatment and about 40% remained consistently out of therapy.

As the large majority of these individuals continue to experience significant symptoms and disability, making services available to them remains a priority. The stigma associated with mental illness and its treatment is a major barrier to treatment seeking among these individuals. Much attention has focused on reducing this stigma using media and educational campaigns. The World Psychiatric Association's program to fight stigma and discrimination against schizophrenia, implemented in over 20 countries, has been one of the most extensive of such efforts.<sup>133</sup> With regard to more common disorders, such public campaigns have resulted in modest improvements in attitudes and treatment seeking.<sup>134,135</sup> There is also evidence from Australia and Germany that public attitudes toward mental health treatment seeking for schizophrenia became more favorable between the early 1990s and the early 2000s.<sup>136,137</sup> However, due to the relative rarity of schizophrenia, the impact of changes in public attitudes on treatment seeking for this disorder may be more difficult to assess than the impact on treatment seeking for the more common mood and anxiety disorders.

Another significant problem affecting the continuity of treatment of schizophrenia in routine care settings is the problem of nonadherence with treatments.<sup>14-16,72</sup> Up to half of schizophrenia patients, experience extended gaps in their treatment in a 1-year period leading to increased hospitalizations and other adverse outcomes.<sup>14,138,139</sup> There have been a number of focused attempts to reduce the frequency of these gaps and to improve the patients' adherence using psychosocial interventions based on motivational interviewing methods, other cognitive-behavioral approaches, psychoeducation, medication self-management, and, more recently, environmental support.<sup>72,140,141</sup> However, the evidence with regard to the efficacy of some of these interventions has been mixed.<sup>142-144</sup> Furthermore, the mental health services have been slow in adopting these interventions.

The problem of unmet need for care in individuals who never initiate treatment or in patients who disengage from treatment is compounded by the unmet needs of a large proportion of patients who are in treatment but who continue to experience significant symptoms and disability. At least half of all patients with schizophrenia treated in routine care settings continue to have significant psychotic or other psychiatric symptoms that are potentially amenable to pharmacological treatments.<sup>49,87</sup> Comparisons of the treatment patterns in routine treatment settings with evidence-based standards show that the overwhelming majority of individuals in treatment receive antipsychotic medications. Furthermore, at least in inpatient settings, the dose of prescribed antipsychotic medications is usually in the therapeutic range. However, there are gaps between current practices

and evidence-based recommendations with regard to the appropriate pharmacological management of nonpsychotic symptoms and side effects, use of psychosocial treatments, and use of medical, dental, and substance disorder services and social services and with regard to coordination among the different services.

There is growing evidence that guideline-conformant treatments could potentially improve patient outcomes and reduce the avertable social and health burden of psychiatric illness<sup>75,145</sup> at minimal additional costs.<sup>75,146</sup> However, services have been slow in adopting care practices that are consistent with the evidence-based guidelines. The individual practice styles and institutional barriers such as lack of resources all likely contribute to the slow adoption of the guideline-consistent practices.<sup>147,148</sup>

Setting performance measures appears to be a straightforward approach to improving conformance with practice guidelines. In the VA health-care system, creating system-wide evidence-based performance measures has had some degree of success in improving conformance with the guidelines.<sup>149–151</sup> For example, one performance measure requiring that all veterans have a primary care provider has led to significant improvement in medical care and receipt of preventive services in patients with severe mental disorders. However, changing clinician's practice styles is not easy.<sup>152</sup> Although introducing incentives, eg, in the form of pay-for-performance arrangements, appears to be an attractive approach to changing clinician's behaviors, when applied in general medical settings, these initiatives have had mixed results, sometimes with unintended adverse consequences.<sup>153–157</sup>

The expansion of managed care in more recent years may have further widened the gap between usual practice and evidence-based standards, at least with regard to the use of psychosocial treatments<sup>66,73,75</sup> and, perhaps, continuity of treatments.<sup>37,74</sup> As Mechanic<sup>65</sup> notes, the trend toward restricting the intensity of services under managed care plans may have led to more homogeneous service patterns and less variation among the different patient populations with different levels of need.

The consistent finding of a reduced use of psychosocial treatments under managed care is disconcerting as psychosocial treatments are often complementary to medications and can potentially address problem areas that are less responsive to medication treatments, such as poor social skills and negative symptoms.<sup>2,158,159</sup> Furthermore, psychosocial treatments are likely more beneficial in the later stages of illness when the acute symptoms have subsided.<sup>2</sup> The long-term impact of managed care on the clinical and social outcomes of the patients with schizophrenia remains to be fully appreciated.<sup>65,75</sup>

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disorder, it is usually secondary to repeated interpersonal failures due to angry outbursts and frequent mood shifts, rather than a result of a persistent lack of social contacts and desire for intimacy. Furthermore, individuals with schizotypal personality disorder do not usually demonstrate the impulsive or manipulative behaviors of the individual with borderline personality disorder. However, there is a high rate of co-occurrence between the two disorders, so that making such distinctions is not always feasible. Schizotypal features during adolescence may be reflective of transient emotional turmoil, rather than an enduring personality disorder.

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## Cluster B Personality Disorders

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### Antisocial Personality Disorder

Diagnostic Criteria	301.7 (F60.2)
<p>A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:</p> <ol style="list-style-type: none"><li>1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.</li><li>2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.</li><li>3. Impulsivity or failure to plan ahead.</li><li>4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.</li><li>5. Reckless disregard for safety of self or others.</li><li>6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.</li><li>7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.</li></ol>	
<p>B. The individual is at least age 18 years.</p>	
<p>C. There is evidence of conduct disorder with onset before age 15 years.</p>	
<p>D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.</p>	

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### Diagnostic Features

The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern has also been referred to as *psychopathy*, *sociopathy*, or *dyssocial personality disorder*. Because **deceit and manipulation are central features of antisocial personality disorder**, it may be especially helpful to integrate information acquired from systematic clinical assessment with information collected from collateral sources.

For this diagnosis to be given, the individual must be at least age 18 years (Criterion B) and must have had a history of some symptoms of conduct disorder before age 15 years (Criterion C). Conduct disorder involves a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. The specific behaviors characteristic of conduct disorder fall into one of four categories: aggression to people and animals, destruction of property, deceitfulness or theft, or serious violation of rules.

The pattern of antisocial behavior continues into adulthood. Individuals with antisocial personality disorder fail to conform to social norms with respect to lawful behavior (Criterion A1). They may repeatedly perform acts that are grounds for arrest (whether they are arrested or not), such as destroying property, harassing others, stealing, or pursuing illegal occupations. Persons with this disorder disregard the wishes, rights, or feelings of others. They are frequently deceitful and manipulative in order to gain personal profit or pleasure (e.g., to obtain money, sex, or power) (Criterion A2). They may repeatedly lie, use an alias, con others, or malingering. A pattern of impulsivity may be manifested by a failure to plan ahead (Criterion A3). Decisions are made on the spur of the moment, without forethought and without consideration for the consequences to self or others; this may lead to sudden changes of jobs, residences, or relationships. Individuals with antisocial personality disorder tend to be irritable and aggressive and may repeatedly get into physical fights or commit acts of physical assault (including spouse beating or child beating) (Criterion A4). (Aggressive acts that are required to defend oneself or someone else are not considered to be evidence for this item.) These individuals also display a reckless disregard for the safety of themselves or others (Criterion A5). This may be evidenced in their driving behavior (i.e., recurrent speeding, driving while intoxicated, multiple accidents). They may engage in sexual behavior or substance use that has a high risk for harmful consequences. They may neglect or fail to care for a child in a way that puts the child in danger.

Individuals with antisocial personality disorder also tend to be consistently and extremely irresponsible (Criterion A6). Irresponsible work behavior may be indicated by significant periods of unemployment despite available job opportunities, or by abandonment of several jobs without a realistic plan for getting another job. There may also be a pattern of repeated absences from work that are not explained by illness either in themselves or in their family. Financial irresponsibility is indicated by acts such as defaulting on debts, failing to provide child support, or failing to support other dependents on a regular basis. Individuals with antisocial personality disorder show little remorse for the consequences of their acts (Criterion A7). They may be indifferent to, or provide a superficial rationalization for, having hurt, mistreated, or stolen from someone (e.g., "life's unfair," "losers deserve to lose"). These individuals may blame the victims for being foolish, helpless, or deserving their fate (e.g., "he had it coming anyway"); they may minimize the harmful consequences of their actions; or they may simply indicate complete indifference. They generally fail to compensate or make amends for their behavior. They may believe that everyone is out to "help number one" and that one should stop at nothing to avoid being pushed around.

The antisocial behavior must not occur exclusively during the course of schizophrenia or bipolar disorder (Criterion D).

## Associated Features Supporting Diagnosis

Individuals with antisocial personality disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal (e.g., feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured, or cocky. They may display a glib, superficial charm and can be quite voluble and verbally facile (e.g., using technical terms or jargon that might impress someone who is unfamiliar with the topic). Lack of empathy, inflated self-appraisal, and superficial charm are features that have been commonly included in traditional conceptions of psychopathy that may be particularly distinguishing of the disorder and more predictive of recidivism in prison or forensic settings, where criminal, delinquent, or aggressive acts are likely to be nonspecific. These individuals may also be irresponsible and exploitative in their sexual relationships. They may have a history of many

sexual partners and may never have sustained a monogamous relationship. They may be irresponsible as parents, as evidenced by malnutrition of a child, an illness in the child resulting from a lack of minimal hygiene, a child's dependence on neighbors or nonresident relatives for food or shelter, a failure to arrange for a caretaker for a young child when the individual is away from home, or repeated squandering of money required for household necessities. These individuals may receive dishonorable discharges from the armed services, may fail to be self-supporting, may become impoverished or even homeless, or may spend many years in penal institutions. Individuals with antisocial personality disorder are more likely than people in the general population to die prematurely by violent means (e.g., suicide, accidents, homicides).

Individuals with antisocial personality disorder may also experience dysphoria, including complaints of tension, inability to tolerate boredom, and depressed mood. They may have associated anxiety disorders, depressive disorders, substance use disorders, somatic symptom disorder, gambling disorder, and other disorders of impulse control. Individuals with antisocial personality disorder also often have personality features that meet criteria for other personality disorders, particularly borderline, histrionic, and narcissistic personality disorders. The likelihood of developing antisocial personality disorder in adult life is increased if the individual experienced childhood onset of conduct disorder (before age 10 years) and accompanying attention-deficit/hyperactivity disorder. Child abuse or neglect, unstable or erratic parenting, or inconsistent parental discipline may increase the likelihood that conduct disorder will evolve into antisocial personality disorder.

## Prevalence

Twelve-month prevalence rates of antisocial personality disorder, using criteria from previous DSMs, are between 0.2% and 3.3%. The highest prevalence of antisocial personality disorder (greater than 70%) is among most severe samples of males with alcohol use disorder and from substance abuse clinics, prisons, or other forensic settings. Prevalence is higher in samples affected by adverse socioeconomic (i.e., poverty) or sociocultural (i.e., migration) factors.

## Development and Course

Antisocial personality disorder has a chronic course but may become less evident or remit as the individual grows older, particularly by the fourth decade of life. Although this remission tends to be particularly evident with respect to engaging in criminal behavior, there is likely to be a decrease in the full spectrum of antisocial behaviors and substance use. By definition, antisocial personality cannot be diagnosed before age 18 years.

## Risk and Prognostic Factors

**Genetic and physiological.** Antisocial personality disorder is more common among the first-degree biological relatives of those with the disorder than in the general population. The risk to biological relatives of females with the disorder tends to be higher than the risk to biological relatives of males with the disorder. Biological relatives of individuals with this disorder are also at increased risk for somatic symptom disorder and substance use disorders. Within a family that has a member with antisocial personality disorder, males more often have antisocial personality disorder and substance use disorders, whereas females more often have somatic symptom disorder. However, in such families, there is an increase in prevalence of all of these disorders in both males and females compared with the general population. Adoption studies indicate that both genetic and environmental factors contribute to the risk of developing antisocial personality disorder. Both adopted and biological children of parents with antisocial personality disorder have an increased

risk of developing antisocial personality disorder, somatic symptom disorder, and substance use disorders. Adopted-away children resemble their biological parents more than their adoptive parents, but the adoptive family environment influences the risk of developing a personality disorder and related psychopathology.

## Culture-Related Diagnostic Issues

Antisocial personality disorder appears to be associated with low socioeconomic status and urban settings. Concerns have been raised that the diagnosis may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy. In assessing antisocial traits, it is helpful for the clinician to consider the social and economic context in which the behaviors occur.

## Gender-Related Diagnostic Issues

Antisocial personality disorder is much more common in males than in females. There has been some concern that antisocial personality disorder may be underdiagnosed in females, particularly because of the emphasis on aggressive items in the definition of conduct disorder.

## Differential Diagnosis

The diagnosis of antisocial personality disorder is not given to individuals younger than 18 years and is given only if there is a history of some symptoms of conduct disorder before age 15 years. For individuals older than 18 years, a diagnosis of conduct disorder is given only if the criteria for antisocial personality disorder are not met.

**Substance use disorders.** When antisocial behavior in an adult is associated with a substance use disorder, the diagnosis of antisocial personality disorder is not made unless the signs of antisocial personality disorder were also present in childhood and have continued into adulthood. When substance use and antisocial behavior both began in childhood and continued into adulthood, both a substance use disorder and antisocial personality disorder should be diagnosed if the criteria for both are met, even though some antisocial acts may be a consequence of the substance use disorder (e.g., illegal selling of drugs, thefts to obtain money for drugs).

**Schizophrenia and bipolar disorders.** Antisocial behavior that occurs exclusively during the course of schizophrenia or a bipolar disorder should not be diagnosed as antisocial personality disorder.

**Other personality disorders.** Other personality disorders may be confused with antisocial personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to antisocial personality disorder, all can be diagnosed. Individuals with antisocial personality disorder and narcissistic personality disorder share a tendency to be tough-minded, glib, superficial, exploitative, and lack empathy. However, narcissistic personality disorder does not include characteristics of impulsivity, aggression, and deceit. In addition, individuals with antisocial personality disorder may not be as needy of the admiration and envy of others, and persons with narcissistic personality disorder usually lack the history of conduct disorder in childhood or criminal behavior in adulthood. Individuals with antisocial personality disorder and histrionic personality disorder share a tendency to be impulsive, superficial, excitement seeking, reckless, seductive, and manipulative, but persons with histrionic personality disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviors. Individuals with histrionic and borderline personality disorders are

manipulative to gain nurturance, whereas those with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification. Individuals with antisocial personality disorder tend to be less emotionally unstable and more aggressive than those with borderline personality disorder. Although antisocial behavior may be present in some individuals with paranoid personality disorder, it is not usually motivated by a desire for personal gain or to exploit others as in antisocial personality disorder, but rather is more often attributable to a desire for revenge.

**Criminal behavior not associated with a personality disorder.** Antisocial personality disorder must be distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder. Only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant functional impairment or subjective distress do they constitute antisocial personality disorder.

## Borderline Personality Disorder

Diagnostic Criteria	301.83 (F60.3)
<p>A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:</p> <ol style="list-style-type: none"><li>1. Frantic efforts to avoid real or imagined abandonment. (<b>Note:</b> Do not include suicidal or self-mutilating behavior covered in Criterion 5.)</li><li>2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.</li><li>3. Identity disturbance: markedly and persistently unstable self-image or sense of self.</li><li>4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (<b>Note:</b> Do not include suicidal or self-mutilating behavior covered in Criterion 5.)</li><li>5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.</li><li>6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).</li><li>7. Chronic feelings of emptiness.</li><li>8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).</li><li>9. Transient, stress-related paranoid ideation or severe dissociative symptoms.</li></ol>	

### Diagnostic Features

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician’s announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this “abandonment” implies they are “bad.” These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic

# Evaluating Competency for Execution after *Madison v. Alabama*

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This article summarizes the evolution of the U.S. Supreme Court's standard for assessing defendants' competency for execution. In *Ford v. Wainwright* (1986), the Court categorically exempted insane defendants from execution but failed to agree on how to define insanity. In *Panetti v. Quarterman* (2007), the Court ruled that defendants may be executed only if they rationally understand why they are being punished. In its most recent decision, the Supreme Court ruled in *Madison v. Alabama* (2019) that defendants who cannot remember committing the original crime may be executed, but dementia may prevent defendants from rationally understanding why they are being punished. The Court remanded the case to Alabama's trial court with instructions to re-determine Mr. Madison's competency. This article concludes by recommending best practices for those who evaluate defendants for competency to be executed.

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In 1986, the U.S. Supreme Court ruled that the Eighth Amendment prohibits executing insane defendants.<sup>1</sup> Years later, in 2007, the Court clarified that the Eighth Amendment forbids executing those who cannot rationally understand why they are to be executed and noted that psychotic disorders may preclude such an understanding.<sup>2</sup> Most recently, in 2019, the Court ruled that a finding of incompetency to be executed is not associated with any particular diagnosis but rather with a specific consequence, i.e., the defendant's inability to rationally understand the reasons for the imposition of the death sentence. This article reviews Supreme Court cases on competency for execution and concludes by recommending best practices for those who evaluate defendants in this capacity.

## **Ford v. Wainwright**

*Ford v. Wainwright* (1986)<sup>1</sup> marked the first time that the U.S. Supreme Court addressed the question

of whether the Eighth Amendment's prohibition against cruel and unusual punishment forbids executing "the insane" (Ref. 1, p 401). Although Alvin Ford appeared competent throughout his trial, he exhibited signs of delusions during his subsequent imprisonment. Unlike many cases, the Court in *Ford* did not achieve a traditional majority opinion. Instead, Justice Powell concurred in part with four other Justices to hold that "the Eighth Amendment prohibits a State from carrying out a sentence of death upon a prisoner who is insane" (Ref. 1, pp 409–10). The Court reasoned that "[i]t is no less abhorrent today than it has been for centuries to exact in penance the life of one whose mental illness prevents him from comprehending the reasons for the penalty or its implications" (Ref. 1, p 417).

Four of the five Justices who formed the plurality believed that defendants should have the right to cross-examine state experts, among other procedural protections.<sup>1</sup> Justice Powell, however, expressed the view that "ordinary adversarial procedures—complete with live testimony, cross-examination, and oral argument by counsel—are not necessarily the best means of arriving at sound, consistent judgments as to a defendant's sanity" (Ref. 1, p 426). The only procedural right that Justice Powell explicitly endorsed was the defendant's right to present "expert psychiatric evidence that may differ from the State's own psychiatric examination" (Ref. 1, p 427).

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The Court plurality declared that “we leave to the State the task of developing appropriate ways to enforce the constitutional restriction upon its execution of sentences” (Ref. 1, pp 416–17). In other words, the plurality did not articulate a specific standard for assessing competency for execution. Justice Powell, however, noted that, at a minimum, states’ statutes agreed that defendants must “know the fact[s] of their impending execution and the reason for it” (Ref. 1, p 422). Justice Powell wrote, “I would hold that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it” (Ref. 1, p 422). Thus, Justice Powell considered a defendant able to understand why they are being executed “[i]f the defendant perceives the connection between his crime and his punishment” (Ref. 1, p 422).

When applying this standard to Mr. Ford, Justice Powell concluded, “According to petitioner’s proffered psychiatric examination, petitioner does not know that he is to be executed, but rather believes that the death penalty has been invalidated. If this assessment is correct, petitioner cannot connect his execution to the crime for which he was convicted” (Ref. 1, pp 422–23).

**Panetti v. Quarterman (2007)**

The Court next addressed competency for execution in *Panetti v. Quarterman* (2007),<sup>2</sup> where Scott Panetti displayed “a fragmented personality, delusions, and hallucinations” (Ref. 2, p 936). After the trial court found Mr. Panetti competent for execution, Mr. Panetti’s counsel filed a writ of *habeas corpus*. The district court<sup>3</sup> held that “[b]ecause the Court finds that Panetti knows he committed two murders, he knows he is to be executed, and he knows the reason the State has given for his execution is his commission of those murders, he is competent to be executed” (Ref. 3, p 712). Mr. Panetti subsequently appealed to the U.S. Court of Appeals for the Fifth Circuit,<sup>4</sup> claiming that:

the Eighth Amendment forbids the execution of a prisoner who lacks a rational understanding of the State’s reason for the execution . . . [and] this understanding is lacking in his case because he believes that, although the State’s purported reason for the execution is his past crimes, the State’s real motivation is to punish him for preaching the Gospel (Ref. 4, pp 817–18).

The Fifth Circuit found Mr. Panetti competent for execution because “‘awareness,’ as that term is used

in *Ford*, is not necessarily synonymous with ‘rational understanding,’ as argued by Panetti” (Ref. 4, p 821). The Supreme Court subsequently granted *certiorari*.<sup>5</sup>

The Court identified the question before it as “whether [Mr. Panetti’s] delusions can be said to render him incompetent” for execution (Ref. 2, p 956). According to the Court, the Fifth Circuit found Mr. Panetti competent because “[f]irst, petitioner is aware that he committed the murders; second, he is aware that he will be executed; and, third, he is aware that the reason the State has given for the execution is his commission of the crimes in question” (Ref. 2, p 956).

Nevertheless, the Court held that “the Court of Appeals’ standard is too restrictive to afford a prisoner the protections granted by the Eighth Amendment” (Ref. 2, pp 956–57). In its decision, the Court criticized the Fifth Circuit for concluding “that its standard foreclosed petitioner from establishing incompetency by . . . showing that his mental illness obstructs a rational understanding of the State’s reason for his execution” (Ref. 2, p 957). As the Court noted, a “prisoner’s awareness of the State’s rationale for an execution is not the same as a rational understanding of it. *Ford* does not foreclose inquiry into the latter” (Ref. 2, p 959). Furthermore, although *Ford* “did not set forth a precise standard for competency” (Ref. 2, p 957), the Court explained that “[t]he beginning of doubt about competence in a case like petitioner’s . . . is a psychotic disorder” (Ref. 2, p 960).

The Court elaborated, writing that “[g]ross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose” (Ref. 2, p 960). If these delusions influence “the prisoner’s concept of reality [so] that he cannot reach a rational understanding of the reason for the execution,” then they preclude execution (Ref. 2, p 958). As a result, states cannot use “a strict test for competency that treats delusional beliefs as irrelevant once the prisoner is aware the State has identified the link between his crime and the punishment to be inflicted” (Ref. 2, p 960).

In its opinion, the Court cautioned that “[a]lthough we reject the standard followed by the Court of Appeals, we do not attempt to set down a rule governing all competency determinations” (Ref. 2, pp 960–

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61). Nevertheless, the Court observed that “[t]he conclusions of physicians, psychiatrists, and other experts in the field will bear upon the proper analysis. Expert evidence may clarify the extent to which severe delusions may render a subject’s perception of reality so distorted that he should be deemed incompetent” (Ref. 2, p 962).

### **Madison v. Alabama (2019)**

First convicted of capital murder of a police officer in 1985, Vernon Madison spent so much time on death row that he “suffered [several] strokes resulting in significant cognitive and physical decline” (Ref. 6, p 1177). During Mr. Madison’s competency for execution hearing in the trial court, a defense expert testified that:

his strokes caused major vascular disorder (also known as vascular dementia) and related memory impairments and that, as a result, he has no memory of committing the murder—the very act that is the reason for his execution. To the contrary, Mr. Madison does not believe he ever killed anyone (Ref. 6, p 1177).

As a result, pursuant to *Ford* and *Panetti*, Mr. Madison’s defense claimed that he was incompetent to be executed because he lacked “a rational understanding of why the state [was] seeking to execute him” (Ref. 6, p 1177).

In contrast, Alabama’s expert testified that Mr. Madison “was able to accurately discuss his legal appeals and legal theories with his attorneys,” and therefore must rationally understand why he was being executed (Ref. 6, p 1177). The trial court overseeing Mr. Madison’s competency hearing agreed with the State of Alabama, finding Mr. Madison competent for execution. Alabama argued that Mr. Madison was competent for execution because he understood his legal situation and did not display any sign of psychosis or delusions, which the Court had focused on in *Panetti*. In response, Mr. Madison’s writ of *habeas corpus* to the relevant federal district court was denied; thereafter, he appealed to the U.S. Court of Appeals for the Eleventh Circuit.

The Eleventh Circuit observed that Mr. Madison qualified as legally blind and had experienced a minimum of two strokes recently (Ref. 6, p 1179). In the aftermath of the first stroke, Mr. Madison regularly requested that someone tell his mother about the stroke, even though she had died several years prior to the incident. After the second stroke, Mr. Madison “reported frequently urinating on himself because ‘no

one will let me out to use the bathroom,’ although he ha[d] a toilet in his cell” (Ref. 6, p 1179). Perhaps most telling, Mr. Madison informed his attorney “that he planned to move to Florida after his release from prison” (Ref. 6, p 1179). On the basis of this evidence, the Eleventh Circuit held that Mr. Madison’s dementia prevented him from “rationally understand[ing] the connection between his crime and his execution” (Ref. 6, p 1186), ruling that “the state court’s decision that Mr. Madison is competent to be executed rested on an unreasonable determination of the facts” (Ref. 6, p 1178) because the state’s expert “never testified that Mr. Madison understands that his execution is connected to the murder he committed” (Ref. 6, p 1187).

In addition, the Eleventh Circuit noted that “the State suggests that only a prisoner suffering from gross delusions can show incompetency under *Panetti*” (Ref. 6, p 1188). Rejecting this argument, the court said that neither *Ford* nor *Panetti* required that “a prisoner must suffer from delusions to be deemed incompetent” (Ref. 6, p 1188). The Eleventh Circuit held that “[a] finding that a man with no memory of what he did wrong has a rational understanding of why he is being put to death is patently unreasonable” (Ref. 6, p 1189). Finally, the Eleventh Circuit determined that, “due to his dementia and related memory impairments, Mr. Madison lacks a rational understanding of the link between his crime and execution” (Ref. 6, p 1190). The state of Alabama appealed this decision to the U.S. Supreme Court.

Pursuant to the Antiterrorism and Effective Death Penalty Act of 1996 (AEDPA), the Supreme Court held in *Dunn v. Madison* (2017)<sup>7</sup> that “[n]either *Panetti* nor *Ford* ‘clearly established’ that a prisoner is incompetent to be executed because of a failure to remember his commission of the crime” (Ref. 7, pp 11–12). Thus, the question of whether an individual recalls committing a crime is “distinct from a failure to rationally comprehend the concepts of crime and punishment as applied in his case” (Ref. 7, p 12). Mr. Madison, therefore, displayed competency to be executed despite severe memory loss because “he recognizes that he will be put to death as punishment for the murder he was found to have committed” (Ref. 7, p 12). The Court ruled that Mr. Madison’s “claim to federal *habeas* relief must fail” because the appeal was pursuant to the highly deferential standards of the AEDPA. The Court further clarified that “[w]e express no

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view on the merits of the underlying question” in any context other than *habeas corpus* proceedings (Ref. 7, p 12). As a result, the Court reversed the Eleventh Circuit’s decision.

Following the Court’s *Dunn v. Madison* opinion, Mr. Madison’s attorney once again alleged on remand that he was incompetent for execution, but Alabama’s Circuit Court for Mobile County disagreed, scheduling an execution date. The Supreme Court issued a stay of execution on January 25, 2018,<sup>8</sup> and granted *certiorari* on January 26, 2018.<sup>9</sup> On February 27, 2019, the Court decided *Madison v. Alabama*,<sup>10</sup> addressing two separate questions: “does the Eighth Amendment forbid execution whenever a prisoner shows that a mental disorder has left him without any memory of committing a crime?”; and “does the Eighth Amendment apply similarly to a prisoner suffering from dementia as to one experiencing psychotic delusions?” (Ref. 10, p 722). In a 5–3 decision written by Justice Kagan, in which Justice Kavanaugh did not participate, the Court held that “a person lacking memory of his crime may yet rationally understand why the State seeks to execute him; if so, the Eighth Amendment poses no bar to his execution” (Ref. 10, p 726). Thus, “[a]ssuming . . . no other cognitive impairment, loss of memory of a crime does not prevent rational understanding of the State’s reasons for resorting to punishment” (Ref. 10, p 727). If memory loss “interacts with other mental shortfalls,” however, and the defendant cannot rationally understand the reason for the punishment, then the defendant is incompetent to be executed (Ref. 10, 727–8). This standard applies to all defendants who have “difficulty preserving any memories, so that even newly gained knowledge (about, say, the crime and punishment) will be quickly forgotten” (Ref. 10, p 728). The same standard also applies “when cognitive deficits prevent the acquisition of such knowledge at all, so that memory gaps go forever uncompensated” (Ref. 10, p 728).

The Court further held that “a person suffering from dementia may be unable to rationally understand the reasons for his sentence; if so, the Eighth Amendment does not allow his execution” (Ref. 10, pp 726–7). According to the Court, the proper standard for determining incompetency for execution is whether “a particular *effect*” exists, specifically, “an inability to rationally understand why the State is seeking execution” (Ref. 10, p 728, *italics in original*). The “precise *cause*” of that effect is irrelevant (Ref. 10, p 728, *italics in original*). It is not the

diagnosis of mental illness, but the consequence of it that governs competency for execution. For this reason, the Court cautioned states against emphasizing a given diagnosis (or its lack) over the “downstream consequence” of that diagnosis (Ref. 10, p 729).

The Court provided additional clarity, writing that “[p]sychosis or dementia, delusions or overall cognitive decline are all the same under *Panetti*, so long as they produce the requisite lack of comprehension” (Ref. 10, p 728). Consistent with this reasoning, “if and when that failure of understanding is present, the rationales kick in—irrespective of whether one disease or another (say, psychotic delusions or dementia) is to blame” (Ref. 10, p 729). As the Court recognized, although many delusions inhibit “the understanding that the Eighth Amendment requires,” some delusions do not (Ref. 10, p 729). Similarly, dementia

can cause such disorientation and cognitive decline as to prevent a person from sustaining a rational understanding of why the State wants to execute him . . . . But dementia also has milder forms, which allow a person to preserve that understanding. Hence the need—for dementia as for delusions as for any other mental disorder—to attend to the particular circumstances of a case . . . (Ref. 10, p 729)

In both scenarios, “[w]hat matters is whether a person has the ‘rational understanding’ *Panetti* requires—not whether he has any particular memory or any particular mental illness” (Ref. 10, p 727). This “kind of comprehension is the *Panetti* standard’s singular focus” (Ref. 10, p 727), thus “the sole inquiry for [reviewing] court[s] remains whether the prisoner can rationally understand the reasons for his death sentence” (Ref. 10, p 728). The Court concluded by remanding the case to Alabama’s trial court “for renewed consideration of Madison’s competency (assuming Alabama sets a new execution date)” (Ref. 10, p 731).

Justice Alito wrote the dissent and was joined by Justices Gorsuch and Thomas. According to the dissent, Mr. Madison’s attorney requested *certiorari* to address the issue of whether states can execute defendants who do not remember committing the crime for which they are to be executed. Following the Court’s grant of *certiorari*, however, the dissent alleged that Mr. Madison’s attorney changed tactics by then arguing that Mr. Madison’s dementia prevented him from rationally understanding why he was to be executed. In Justice Alito’s view, the Majority erred by ruling on a question that the Court did not agree to address.

## Best Practices for Evaluators

When discussing whether the American Academy of Psychiatry and the Law (AAPL) should oppose executions as a professional organization, Halpern and colleagues called upon AAPL to “tak[e] a stand on vital social issues that are clearly in the public interest” (Ref. 11, p 182). This same principle holds true when it comes to establishing the minimum requirements that professionals should meet in conducting evaluations of defendants’ competency for execution.<sup>12</sup> Absent instruction from professional organizations like AAPL, we recommend that, at a minimum, qualified evaluators must be licensed psychologists, psychiatrists, or physicians in good standing in their profession with extensive experience assessing mental health disorders prior to being considered for appointment as an expert evaluator. This standard mirrors the minimum requirements that legal scholars have proposed for professionals who assess capital defendants for intellectual disability.<sup>13</sup>

Evaluators should meet with the defendant in person<sup>14</sup> for an appropriate length of time<sup>15,16</sup> when conducting a competency evaluation. What constitutes an appropriate period of time will necessarily vary based on the evaluatee’s mental state. In situations where the evaluatee is too impaired to meaningfully participate in the interview process, interviews may be brief. Other interviews, however, could last several hours. Because the required threshold for establishing competence for execution is relatively low, a single meeting may be sufficient to evaluate defendants who are cognitively intact and not actively displaying symptoms of mental illness. In other, more complex situations involving defendants exhibiting cognitive decline and active symptoms of mental illness, it may be necessary to meet with the defendant on multiple occasions.<sup>12</sup> The evaluations themselves should take place in “a private, distraction-free area,” which may require temporarily moving the defendant off of death row (Ref. 12, p 209), where noise pollution is prevalent.<sup>17</sup>

Because competence for execution evaluations require “a strong commitment to . . . the most thorough and detailed evaluation” possible, Radelet and Barnard recommended videotaping all evaluations (Ref. 18, p 46). AAPL, however, has previously declined to endorse “a blanket rule of requiring videotaping in all forensic interviews” (Ref. 19, p 357). Evaluators, therefore,

should educate themselves about the specific videotaping requirements of their associated jurisdictions. If the jurisdiction does not require videotaping, evaluators should rely on their own judgment and personal preferences when deciding whether to videotape evaluations.

In addition to face-to-face interviews, a forensic psychologist recommended that evaluators obtain information from as many of the following sources as possible:

- (1) prison medical records; (2) prison psychiatric records; (3) psychiatric records prior to incarceration; (4) academic records, including prior intellectual testing with raw data; (5) records of past psychological evaluations; (6) any and all videotapes made of the inmate; (7) military or veterans affairs records; (8) records and transcripts of testimony of the inmate; (9) writings or letters of the inmate [within] the prior year; (10) videotapes of the inmate demonstrating bizarre behavior; and (11) art work of the inmate (Ref. 16, p 49).

While this list serves as a useful overview of materials that evaluators may wish to explore, it need not be followed rigidly. Reviewing videotapes featuring the evaluatee is generally good practice, for example, but some videos are likely to prove more relevant than others. Evaluators, therefore, should focus the majority of their attention on recent video footage because this speaks more directly to the evaluatee’s competence to be executed. Similarly, routine surveillance footage may have limited value for ascertaining the evaluatee’s competency for execution. Academic records, including tests conducted, are sometimes a useful piece of information, but they may be less relevant if they are several decades old. Evaluatees’ artwork is also unlikely to be relevant except in a few rare instances.

In light of the Court’s *Madison* ruling, evaluators should pay careful attention to any medical diagnoses or conditions that may render defendants’ ability to formulate a rational understanding of why they are to be executed exceptionally difficult. Per *Madison*, diagnoses themselves are ultimately immaterial, but they may still serve to highlight cases that require closer examination. This topic was raised by the *Panetti* Court, in which it instructed that the presence of psychosis indicated the need to thoroughly evaluate defendants for incompetency. According to the Court, neither medical nor psychological diagnoses automatically qualify defendants as incompetent to be executed. Nevertheless, these labels may reasonably be construed as a crude screening tool signaling “[t]he beginning of doubt about competence” (Ref.

Competency for Execution after *Madison v. Alabama*

2, p 960). The same is true for major medical events like strokes, such as Mr. Madison experienced. The broader significance of *Madison*, therefore, is that the Court recognized that defendants' medical histories may directly influence their ability to rationally understand why they are to be executed, although specific diagnoses themselves are insufficient to establish incompetency. As a result, evaluators should be sure to review relevant medical records and construct a detailed medical history whenever possible.

Finally, evaluators should engage in serious self-reflection before participating in the treatment or reevaluation of incompetent capital defendants given that successful treatment exposes the evaluatee to death via execution.<sup>18,20</sup> Evans<sup>21</sup> argued that these behaviors constitute "the fringe of what the profession has defined as ethical conduct" (Ref. 21, p 264), although this sentiment is not shared universally.<sup>22</sup> Radelet and Barnard<sup>23</sup> recommended that states protect evaluators from "the ethical dilemma created by the demand to treat prisoners so that they can be executed" by passing legislation permanently commuting incompetent defendants' death sentences to life imprisonment without possibility of parole (Ref. 23, p 306).

In conclusion, while the *Madison* Court preserved a broad interpretation of the category of persons who may qualify as incompetent for execution, the Court declined to address a number of related concerns surrounding competency evaluations. In the absence of guidance from the Court, professional organizations such as AAPL may wish to take the advice of Halpern and colleagues<sup>11</sup> and play a more prominent role by engaging in the debate. As a first step, we recommend that AAPL create a minimum set of standards that individuals must meet before they qualify to conduct evaluations of competency to be executed.

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**IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF ARIZONA**

Clarence Wayne Dixon,  
Petitioner,  
vs.

David Shinn, et al.,  
Respondents.

No. CV-14-258-PHX-DJH  
DEATH-PENALTY CASE

**NOTICE OF APPEAL**

Petitioner Clarence Wayne Dixon, through counsel, hereby gives notice of his appeal to the United States Court of Appeals for the Ninth Circuit from this Court's Order and Judgment denying his Petition for Writ of Habeas Corpus, Certificate of Appealability, and Motion for Stay of Execution, all entered on May 10, 2022. (Dist. Ct. Doc. Nos. 96, 97.)

///

1 Respectfully submitted this 10th day of May, 2022.

2  
3 Jon M. Sands  
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5 District of Arizona

6 Cary Sandman  
7 Amanda C. Bass  
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10 s/ Amanda C. Bass  
11 Counsel for Petitioner  
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**Certificate of Service**

I hereby certify that on May 10, 2022, I electronically filed the foregoing Notice of Appeal with the Clerk's Office using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

s/ Jessica Golightly  
Assistant Paralegal  
Capital Habeas Unit

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[APPEAL](#),[ATTYADD](#),[CLOSED](#),[CMX](#),[DEATH-PENALTY](#)

**U.S. District Court  
DISTRICT OF ARIZONA (Phoenix Division)  
CIVIL DOCKET FOR CASE #: 2:14-cv-00258-DJH**

Dixon v. Ryan et al  
Assigned to: Judge Diane J Humetewa  
Case in other court: Ninth Circuit, 16-99006 - Mandate 05/28/20  
Cause: 28:2254 Ptn for Writ of H/C - Stay of Execution

Date Filed: 02/11/2014  
Date Terminated: 03/16/2016  
Jury Demand: None  
Nature of Suit: 535 Prisoner: Death Penalty  
- Habeas Corpus  
Jurisdiction: Federal Question

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Date Filed	#	Docket Text

02/11/2014	<a href="#"><u>1</u></a>	MOTION to Stay by Clarence Wayne Dixon. (3 pages) (MHU) (Entered: 02/11/2014)
02/11/2014	<a href="#"><u>2</u></a>	STATEMENT of Intent by Petitioner Clarence Wayne Dixon. (1 page) (MHU) (Entered: 02/11/2014)
02/11/2014	<a href="#"><u>3</u></a>	APPLICATION for Leave to Proceed In Forma Pauperis by Clarence Wayne Dixon. (2 pages) (MHU) (Entered: 02/11/2014)
02/11/2014	<a href="#"><u>4</u></a>	MOTION to Appoint Counsel by Clarence Wayne Dixon. (5 pages) (MHU) (Entered: 02/11/2014)
02/12/2014	<a href="#"><u>5</u></a>	ORDER granting <a href="#"><u>1</u></a> Motion to Stay Execution of Death Sentence and staying Petitioner's Warrant of Execution pending the filing of a Petition for Writ of Habeas Corpus detailing all of Petitioners known federal claims and resolution of the issues raised therein. FURTHER ORDERED that Petitioner remain in the custody of the Arizona Department of Corrections pending further order of this Court. FURTHER ORDERED that the Clerk of Court make immediate telephonic notice of this Order to Charles L. Ryan, Director of the Arizona Department of Corrections; Thomas Horne, Attorney General of the State of Arizona; Janet Johnson, Clerk of the Arizona Supreme Court; and Lance Hetmer, Warden of the Arizona State Penitentiary at Florence, and that a copy of this Order be served on these individuals by the United States Marshal forthwith. FURTHER ORDERED that the Clerk of Court forward a copy of this Order to Petitioner Clarence Wayne Dixon, ADOC #038977, Eyman-Browning Unit, P.O. Box3400, Florence, AZ 85312-3400. Signed by Judge Cindy K Jorgenson on 2/12/14.(MAP) (Entered: 02/12/2014)
02/14/2014	<a href="#"><u>6</u></a>	ORDER OF APPOINTMENT AND GENERAL PROCEDURES granting Petitioner's <a href="#"><u>4</u></a> Motion for Appointment of Counsel. Jon M. Sands, Federal Public Defender for the District of Arizona, is appointed as Counsel for Petitioner in this federal habeas corpus proceeding. The Federal Public Defender is authorized to designate an Assistant Federal Public Defender to handle the case. FURTHER ORDERED granting <a href="#"><u>3</u></a> Petitioner's Application to Proceed In Forma Pauperis. FURTHER ORDERED that the designated Assistant Federal Public Defender shall file a notice of appearance or substitution with the Court within ten (10) days from receipt of this Order. FURTHER ORDERED that the Arizona Attorney General shall file a notice of appearance with the Court within ten (10) days from receipt of this Order. IT IS FURTHER ORDERED that the following procedures shall govern the briefing and resolution of this matter: Case Management Conference (CMC): Case Management Conference will be held on Thursday, May 29, 2014, at 2:00 p.m. SEE ORDER FOR FULL DETAILS RE CASE MANAGEMENT. FURTHER ORDERED that pursuant to Local Rule Civil 3.8(e) this case is reassigned to Judge Neil V. Wake and shall be redesignated as No. CV-14-258-PHX-NVW. FURTHER ORDERED that the Clerk of Court send a copy of this Order either electronically or through postal mail to Jeffrey Zick, Assistant Arizona Attorney General. FURTHER ORDERED that the Clerk of Court forward a copy of this Order to Petitioner Clarence Wayne Dixon. Signed by Judge Cindy K Jorgenson on 2/14/14.(MAP) (Entered: 02/14/2014)
02/14/2014	<a href="#"><u>7</u></a>	NOTICE OF ATTORNEY SUBSTITUTION: Jeffrey A. Zick appearing for Charles L Ryan. . (Zick, Jeffrey) (Entered: 02/14/2014)
02/20/2014	<a href="#"><u>8</u></a>	NOTICE of Appearance by Dale A Baich on behalf of Clarence Wayne Dixon. (Baich, Dale) (Entered: 02/20/2014)
02/28/2014	<a href="#"><u>9</u></a>	SERVICE EXECUTED: Affidavit of Service re: Stay of Execution upon Thomas Horne, Arizona Attorney General on 2/14/2014. (LSP) (Entered: 03/03/2014)
02/28/2014	<a href="#"><u>10</u></a>	SERVICE EXECUTED: Affidavit of Service re: Stay of Execution upon Janet Johnson, Clerk of Arizona Supreme Court on 2/14/2014. (LSP) (Entered: 03/03/2014)

02/28/2014	<a href="#"><u>11</u></a>	SERVICE EXECUTED: Affidavit of Service re: Stay of Execution upon Lance Hetmer, Warden ASPC at Florence on 2/25/2014. (LSP) (Entered: 03/03/2014)
02/28/2014	<a href="#"><u>12</u></a>	SERVICE EXECUTED: Affidavit of Service re: Stay of Execution upon Charles L Ryan, Director ADOC on 2/14/2014. (LSP) (Entered: 03/03/2014)
04/15/2014	<a href="#"><u>13</u></a>	STRICKEN by Doc. 16 - NOTICE of Appearance by Colleen Clase on behalf of Leslie James. (Clase, Colleen) Modified on 4/21/2014 (NKS). (Entered: 04/15/2014)
04/15/2014	<a href="#"><u>14</u></a>	STRICKEN by Doc. 16 - First MOTION for Leave to Appear Telephonically by Leslie James. (Attachments: # <a href="#"><u>1</u></a> Text of Proposed Order)(Clase, Colleen) Modified on 4/21/2014 (NKS). (Entered: 04/15/2014)
04/18/2014	<a href="#"><u>15</u></a>	MOTION to Strike <a href="#"><u>13</u></a> Notice of Appearance/Association of Counsel, <a href="#"><u>14</u></a> First MOTION for Leave to Appear Telephonically by Clarence Wayne Dixon. (Attachments: # <a href="#"><u>1</u></a> Text of Proposed Order Proposed Order for Motion to Strike)(Stone, Sarah) (Entered: 04/18/2014)
04/21/2014	<a href="#"><u>16</u></a>	ORDER granting Petitioner's Motion to Strike (Doc. <a href="#"><u>15</u></a> ). FURTHER ORDERED striking the Notice of Appearance of Counsel for Crime Victim (Doc. <a href="#"><u>13</u></a> ) and the Crime Victim's Request to be Present Telephonically (Doc. <a href="#"><u>14</u></a> ). Signed by Judge Neil V. Wake on 4/21/14. (NKS) (Entered: 04/21/2014)
04/22/2014	<a href="#"><u>17</u></a>	NOTICE of Appearance by Colleen Clase on behalf of Leslie James. (Clase, Colleen) (Entered: 04/22/2014)
04/22/2014	<a href="#"><u>18</u></a>	*MOTION re: Crime Victims Request to be Present Telephonically at the May 29th, 2014 Case Management Conference by Victim Leslie James. (Attachments: # <a href="#"><u>1</u></a> Text of Proposed Order)(Clase, Colleen) *Modified to add motion type on 4/22/2014 (LSP). (Entered: 04/22/2014)
04/28/2014	<a href="#"><u>19</u></a>	ORDER that Crime Victim Leslie James's Request to be Present Telephonically at the May 29, 2014 Case Management Conference (Doc. <a href="#"><u>18</u></a> ) is GRANTED. Signed by Judge Neil V. Wake on 4/28/14. (NKS) (Entered: 04/28/2014)
05/14/2014	<a href="#"><u>20</u></a>	REPORT of Joint Report re: Statute of Limitations and Proposed Briefing Schedule by Petitioner Clarence Wayne Dixon. (Stone, Sarah) (Entered: 05/14/2014)
05/20/2014	<a href="#"><u>21</u></a>	NOTICE of Appearance by Karen M Wilkinson on behalf of Clarence Wayne Dixon. (Wilkinson, Karen) (Entered: 05/20/2014)
05/29/2014	22	<p>MINUTE ENTRY for proceedings held before Judge Neil V. Wake: Scheduling Conference held on 5/29/2014. Proposed scheduling order discussed. The Court adopts the proposed schedule. Separate order to follow.</p> <p>APPEARANCES: Sarah Stone and Karen Wilkinson for Petitioner. Jeffrey Zick for Respondents. Colleen Clase for Crime Victim Leslie James. Crime Victim Leslie James also present telephonically. (Court Reporter Laurie Adams.) Hearing held 2:04 p.m. to 2:10 p.m. This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (NKS) (Entered: 05/29/2014)</p>
05/29/2014	<a href="#"><u>23</u></a>	SCHEDULING ORDER: Petitioner shall file a Petition for Writ of Habeas Corpus no later than 10/21/14. Respondents shall file an Answer no later than 12/22/14. Petitioner shall file a reply no later than 01/21/15. FURTHER ORDERED that, absent circumstances beyond counsel's control, the Court is not inclined to continue the deadlines set forth herein. FURTHER ORDERED that the pleadings, briefs, and motions scheduled in this order shall conform to the format set forth in the Court's Order of Appointment and General Procedures (Doc. <a href="#"><u>6</u></a> ). See order for complete details. Signed by Judge Neil V. Wake on 5/29/14. (NKS) (Entered: 05/29/2014)

07/01/2014	<a href="#">24</a>	Minute Order: NOTICE OF REASSIGNMENT. This matter is reassigned to Judge Diane J Humetewa for all further proceedings. All documents filed in this action should bear the initials DJH as part of the complete case number (see revised case number above). All pending deadlines and hearings are AFFIRMED unless reset by separate order. This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (SJF) (Entered: 07/01/2014)
10/03/2014	<a href="#">25</a>	First MOTION for Extension of Time to File Petition for Writ of Habeas Corpus by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Exhibit Attachment A, # <a href="#">2</a> Text of Proposed Order proposed order)(Stone, Sarah) (Entered: 10/03/2014)
10/06/2014	<a href="#">26</a>	ORDER granting <a href="#">25</a> Motion for Extension of Time Deadline. Petitioner shall file his Petition for Writ of Habeas Corpus no later than December 19, 2014. Respondents shall file an Answer no later than February 20, 2015. Petitioner shall file a reply no later than March 20, 2015. See PDF document for details. Signed by Judge Diane J Humetewa on 10/6/14.(LSP) (Entered: 10/06/2014)
12/19/2014	<a href="#">27</a>	*PETITION for Writ of Habeas Corpus Pursuant to 28-USC 2254 by Petitioner Clarence Wayne Dixon. (Stone, Sarah) *Modified to correct event type on 12/22/2014 (LSP). (Entered: 12/19/2014)
01/07/2015	<a href="#">28</a>	NOTICE of Attorney Withdrawal <i>Karen Wilkinson</i> filed by Dale A Baich. (Baich, Dale) (Entered: 01/07/2015)
01/08/2015	<a href="#">29</a>	NOTICE of Appearance by Ginger Jarvis on behalf of Charles L Ryan. (Jarvis, Ginger) (Entered: 01/08/2015)
01/20/2015	<a href="#">30</a>	*NOTICE OF ATTORNEY SUBSTITUTION: John Pressley Todd appearing for Charles L Ryan. Attorney Ginger Jarvis terminated. . (Todd, John) *Modified to correct event type on 1/21/2015 (LSP). (Entered: 01/20/2015)
02/17/2015	<a href="#">31</a>	First MOTION for Extension of Time to File Answer by Charles L Ryan. (Attachments: # <a href="#">1</a> Text of Proposed Order Order)(Todd, John) (Entered: 02/17/2015)
02/19/2015	<a href="#">32</a>	ORDER granting <a href="#">31</a> Respondents' Motion for Extension of Time to Answer re: <a href="#">27</a> Petition for Writ of Habeas Corpus. Respondents shall file their Answer no later than Friday, March 6, 2015. Signed by Judge Diane J Humetewa on 2/19/15.(LSP) (Entered: 02/19/2015)
02/24/2015	<a href="#">33</a>	MOTION for Extension of Time to File Response/Reply to Answer to Petition for Writ of Habeas Corpus by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Text of Proposed Order to Modify Time to File Reply)(Stone, Sarah) (Entered: 02/24/2015)
03/06/2015	<a href="#">34</a>	Second MOTION for Extension of Time to File Answer by Charles L Ryan. (Attachments: # <a href="#">1</a> Text of Proposed Order Proposed Order)(Todd, John) (Entered: 03/06/2015)
03/09/2015	<a href="#">35</a>	ORDER granting <a href="#">33</a> Motion for Extension of Time to File Reply to Respondents' Answer re: <a href="#">27</a> PETITION for Writ of Habeas Corpus pursuant to 28-USC 2254 and granting <a href="#">34</a> Motion for Extension of Time to Answer. Respondents' Answer shall be filed no later than 3/12/2015. Petitioner's reply shall be filed no later than 4/10/2015. Signed by Judge Diane J Humetewa on 3/9/2015.(ACL) (Entered: 03/09/2015)
03/12/2015	<a href="#">36</a>	*ANSWER to <a href="#">27</a> PWHC by Charles L Ryan.(Todd, John) *Modified to add document number on 3/13/2015 (LSP). (Entered: 03/12/2015)
03/12/2015	<a href="#">37</a>	*RESPONSE to <a href="#">5</a> and <a href="#">6</a> Court's Orders by Respondent Charles L Ryan. (Attachments: # <a href="#">1</a> Exhibit A - B, # <a href="#">2</a> Exhibit C - E, # <a href="#">3</a> Exhibit E (part 2), # <a href="#">4</a> Exhibit E (part 3) - H, # <a href="#">5</a> Exhibit I (part 1), # <a href="#">6</a> Exhibit I(part 2), # <a href="#">7</a> Exhibit J (part 1), # <a href="#">8</a> Exhibit J (part 2) - O, # <a href="#">9</a> Exhibit P - FFF, # <a href="#">10</a> Exhibit GGG(part 1), # <a href="#">11</a> Exhibit GGG (part 2), # <a href="#">12</a> Exhibit GGG

		(part 3))(Todd, John) *Modified to add document numbers on 3/13/2015 (LSP). (Entered: 03/12/2015)
03/12/2015	<a href="#">38</a>	Additional Attachments to Main Document re: <a href="#">37</a> Response to Court Order by Respondent Charles L Ryan. (Attachments: # <a href="#">1</a> Exhibit KKK - BBBB, # <a href="#">2</a> Exhibit CCCC (part 1), # <a href="#">3</a> Exhibit CCCC (part 2), # <a href="#">4</a> Exhibit DDDD - JJJJ, # <a href="#">5</a> Exhibit KKKK - LLLL, # <a href="#">6</a> Exhibit MMMM - RRRR, # <a href="#">7</a> Exhibit SSSS - UUUU, # <a href="#">8</a> Exhibit VVVV - DDDDD) (Todd, John) (Entered: 03/12/2015)
04/10/2015	<a href="#">39</a>	*REPLY re: <a href="#">36</a> Respondent's Answer to <a href="#">27</a> Petition for Writ of Habeas Corpus by Petitioner Clarence Wayne Dixon. (Stone, Sarah) *Modified to add document number on 4/13/2015 (LSP). (Entered: 04/10/2015)
04/10/2015	<a href="#">40</a>	NOTICE re: of Filing Addt'l Portions of State Court Record by Clarence Wayne Dixon re: <a href="#">38</a> Additional Attachments to Main Document, <a href="#">37</a> Response . (Attachments: # <a href="#">1</a> Exhibit Supplemental State Record)(Stone, Sarah) (Entered: 04/10/2015)
04/10/2015	<a href="#">41</a>	*MOTION to Seal, Filed by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Text of Proposed Order to File Sealed Portion of State Court Record)(Stone, Sarah) *Modified to correct event type on 4/13/2015 (LSP). (Entered: 04/10/2015)
04/10/2015	<a href="#">42</a>	*FILED at Doc. <a href="#">47</a> * SEALED LODGED Proposed Sealed Portion of State Court Record re: <a href="#">41</a> Motion to Seal. Document to be filed by Clerk if Motion or Stipulation to Seal is granted. Filed by Clarence Wayne Dixon. (Stone, Sarah) *Modified to add link to motion to seal on 4/13/2015 (CEI). *Modified on 5/6/2015 (MAP)*. (Entered: 04/10/2015)
04/29/2015	<a href="#">43</a>	MOTION for Extension of Time to File <i>Motion for Evidentiary Development</i> by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Text of Proposed Order for Extension of Time to file Mtn for Evidentiary Development)(Stone, Sarah) (Entered: 04/29/2015)
04/30/2015	<a href="#">44</a>	*RESPONSE in Opposition to <a href="#">43</a> Petitioner's Unopposed Request for Extension of Time to File Motion for Evidentiary Development by Victim Leslie James. (Clase, Colleen) *Modified to correct event type on 4/30/2015 (LSP). (Entered: 04/30/2015)
04/30/2015	<a href="#">45</a>	*REPLY to Response to Motion re: <a href="#">44</a> Objection/Response by Victim to <a href="#">43</a> Unopposed Request for Extension of Time to File Motion for Evidentiary Development by Petitioner Clarence Wayne Dixon. (Stone, Sarah) *Modified to correct event type and to add document number on 5/1/2015 (LSP). (Entered: 04/30/2015)
05/06/2015	<a href="#">46</a>	ORDER granting <a href="#">41</a> Motion to Seal. The Clerk of Court shall file the state court document, lodged at Doc. <a href="#">42</a> , under seal. Signed by Judge Diane J Humetewa on 5/6/15. (MAP) (Entered: 05/06/2015)
05/06/2015	<a href="#">47</a>	Sealed Portion of State Court Record (Re <a href="#">40</a> ) filed by Clarence Wayne Dixon. (MAP) (Entered: 05/06/2015)
05/06/2015	<a href="#">48</a>	ORDER granting <a href="#">43</a> Motion for Extension of Time to File as follows: (1) Petitioner's motion for evidentiary development shall be filed no later than 6/10/15. (2) Respondents shall file their response no later than 7/10/15. (3) Petitioner shall file his reply no later than 7/27/15. Signed by Judge Diane J Humetewa on 5/6/15.(MAP) (Entered: 05/06/2015)
06/10/2015	<a href="#">49</a>	MOTION for Evidentiary Development by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Exhibit Index and Exhibits 1-5, # <a href="#">2</a> Exhibits 6-11, # <a href="#">3</a> Exhibits 12-16, # <a href="#">4</a> Exhibits 17a-17v, # <a href="#">5</a> Exhibits 17w-17hh, # <a href="#">6</a> Exhibits 18-26, # <a href="#">7</a> Exhibits 27-29)(Stone, Sarah) Modified on 6/11/2015 (REW). (Main Document 49 replaced on 6/11/2015) (LAD). (Attachment 1 replaced on 6/11/2015) (LAD). (Attachment 2 replaced on 6/11/2015) (LAD). (Attachment 3 replaced on 6/11/2015) (LAD). (Attachment 4 replaced on 6/11/2015) (LAD). (Attachment 5 replaced on 6/11/2015) (LAD). (Attachment 6 replaced

		on 6/11/2015) (LAD). (Attachment 7 replaced on 6/11/2015) (LAD). (Entered: 06/10/2015)
06/10/2015	<a href="#">50</a>	Additional Attachments to Main Document re: <a href="#">49</a> MOTION for Evidentiary Development by Petitioner Clarence Wayne Dixon. (Main Document: Exhibits 30-43; Attachments: # <a href="#">1</a> Exhibits 44-51, # <a href="#">2</a> Exhibits 52-66, # <a href="#">3</a> Exhibits 67-76, # <a href="#">4</a> Exhibits 77-84 Pt 1, # <a href="#">5</a> Exhibit 84 pt 2)(Stone, Sarah) Modified on 6/11/2015 (REW). (Main Document 50 replaced on 6/11/2015) (LAD). (Attachment 1 replaced on 6/11/2015) (LAD). (Attachment 2 replaced on 6/11/2015) (LAD). (Attachment 3 replaced on 6/11/2015) (LAD). (Attachment 4 replaced on 6/11/2015) (LAD). (Attachment 5 replaced on 6/11/2015) (LAD). (Entered: 06/10/2015)
06/10/2015	<a href="#">51</a>	MOTION to Seal Document by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Text of Proposed Order to File Exhibits Under Seal)(Stone, Sarah) (Entered: 06/10/2015)
06/10/2015	<a href="#">52</a>	*FILED at <a href="#">54</a> - SEALED LODGED Proposed Exhibits to Motion for Evidentiary Development re: <a href="#">51</a> MOTION to Seal Document. Document to be filed by Clerk if Motion or Stipulation to Seal is granted. Filed by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Exhibit Exh 47)(Stone, Sarah) Modified on 6/19/2015 (REW). (Entered: 06/10/2015)
06/19/2015	<a href="#">53</a>	ORDER granting Petitioner's <a href="#">51</a> Motion to Seal; the Clerk shall file the exhibits, lodged at <a href="#">52</a> under seal. Signed by Judge Diane J Humetewa on 6/19/15.(REW) (Entered: 06/19/2015)
06/19/2015	<a href="#">54</a>	Sealed Exhibits 14 and 47 re: <a href="#">49</a> Motion for Evidentiary Development filed by Clarence Wayne Dixon. (REW) (Entered: 06/19/2015)
07/10/2015	<a href="#">55</a>	RESPONSE in Opposition re: <a href="#">49</a> MOTION for Evidentiary Development filed by Charles L Ryan. (Todd, John) (Entered: 07/10/2015)
07/27/2015	<a href="#">56</a>	*REPLY to <a href="#">55</a> Response in Opposition to <a href="#">49</a> Motion for Evidentiary Development by Petitioner Clarence Wayne Dixon. (Stone, Sarah) *Modified to correct event type and add document number on 7/28/2015 (KGM). (Entered: 07/27/2015)
07/29/2015	<a href="#">57</a>	*NOTICE re: Supplemental Authority to <a href="#">55</a> RESPONSE in Opposition re: 49 MOTION for Evidentiary Development by Charles L Ryan . (Todd, John) *Modified to add document number on 7/30/2015 (KGM). (Entered: 07/29/2015)
10/07/2015	<a href="#">58</a>	ORDER that the Clerk of the Arizona Supreme Court transmit to Brian Karth, Clerk, United States District Court, 401 West Washington Street, Suite 130, SPC 1, Phoenix, Arizona 85003-2118, the Record on Appeal in Maricopa County Superior Court No. CR2002-019595, including all transcripts but excluding exhibits, filed as part of the direct appeal in No. CR-08-0025-AP. IT IS FURTHER ORDERED that the Clerk of Court send a copy of this Order to: Janet Johnson, Clerk of the Arizona Supreme Court, 1501 W. Washington, Suite 402, Phoenix, Arizona 85007-3329. Signed by Judge Diane J Humetewa on 10/7/15. (EJA) (Entered: 10/07/2015)
10/28/2015	<a href="#">59</a>	NOTICE of submitting CD containing the certified record of Arizona Supreme Court case number CR-08-0025-AP and Maricopa County Superior Court case number CR2002019595 as to Clarence Wayne Dixon. (LSP) (Entered: 10/29/2015)
10/28/2015		CD - Certified Record from Arizona Supreme Court received and stored in the Phoenix file room. This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (CAD) (Entered: 10/30/2015)
11/30/2015	<a href="#">60</a>	NOTICE of Attorney Substitution by Paula K Harms. (Harms, Paula) (Entered: 11/30/2015)
03/16/2016	<a href="#">61</a>	ORDER that Petitioner's Petition for Writ of Habeas Corpus Doc. <a href="#">27</a> ) is DENIED. The

		Clerk shall enter judgment. The stay of execution entered by this Court on February 12, 2014 (Doc. <a href="#">5</a> ), is VACATED. IT IS FURTHER ORDERED denying <a href="#">49</a> Petitioner's motion for evidentiary development. IT IS FURTHER ORDERED granting a certificate of appealability with respect to Claims 1, 3 (A), and 9. The Clerk shall forward a courtesy copy of this Order to the Clerk of the Arizona Supreme Court. Signed by Judge Diane J Humetewa on 3/16/16.(LSP) (Entered: 03/16/2016)
03/16/2016	<a href="#">62</a>	CLERK'S JUDGMENT it is ordered and adjudged that pursuant to the Court's Order filed March 16, 2016, Petitioner's Petition for Writ of Habeas Corpus pursuant to 28 U. S. C. § 2254 is denied. Petitioner to take nothing and this action is hereby dismissed. (LSP) (Entered: 03/16/2016)
04/13/2016	<a href="#">63</a>	* MOTION to Amend/Correct Judgment by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Text of Proposed Order, # <a href="#">2</a> Exhibit)(Harms, Paula) *Modified to correct event type on 4/14/2016 (KGM). (Entered: 04/13/2016)
05/10/2016	<a href="#">64</a>	ORDER denying Petitioner's <a href="#">63</a> Motion to Alter or Amend the Judgment. Signed by Judge Diane J Humetewa on 5/10/2016. (See Order for details.)(LFIG) (Entered: 05/10/2016)
05/18/2016	<a href="#">65</a>	*SUPPLEMENT Petitioners Supplemental Exhibit to <a href="#">63</a> Motion to Alter or Amend the Judgment by Petitioner Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Exhibit A to Petitioners Supplemental Exhibit to Motion to Alter or Amend the Judgment)(Harms, Paula) *Modified to add document number on 5/19/2016 (LSP). (Entered: 05/18/2016)
06/09/2016	<a href="#">66</a>	NOTICE OF APPEAL to 9th Circuit Court of Appeals re: <a href="#">61</a> Order on Motion for Miscellaneous Relief, <a href="#">64</a> Order on Motion to Amend/Correct, <a href="#">62</a> Clerks Judgment by Clarence Wayne Dixon. (Harms, Paula) (Entered: 06/09/2016)
06/13/2016	<a href="#">67</a>	USCA Case Number re: <a href="#">66</a> Notice of Appeal. Case number 16-99006, Ninth Circuit. (Copies sent by the Ninth Circuit.) (KMG) (Entered: 06/13/2016)
10/28/2016		Document was filed in the wrong case. All docket text associated with the entry has been removed on 11/30/2016 (CEI) (Entered: 11/30/2016)
08/16/2019	<a href="#">69</a>	NOTICE of Attorney Withdrawal <i>Paula K. Harms</i> filed by Paula K Harms. (Harms, Paula) (Entered: 08/16/2019)
10/28/2019	<a href="#">70</a>	*RECALLED pursuant to (Doc. <a href="#">71</a> ) MANDATE of USCA Affirming re: 16-99006, <a href="#">66</a> Notice of Appeal filed by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Opinion, # <a href="#">2</a> Order) (EJA) Modified on 10/29/2019 (EJA). (Entered: 10/28/2019)
10/29/2019	<a href="#">71</a>	ORDER of USCA: The mandate issued on October 28, 2019 is recalled as issued in error, re: 16-99006 <a href="#">66</a> Notice of Appeal filed by Clarence Wayne Dixon. (EJA) (Entered: 10/29/2019)
05/28/2020	<a href="#">72</a>	MANDATE of USCA (16-99006) affirming the decision of the district court re: <a href="#">66</a> Notice of Appeal filed by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Opinion)(LAD) (Entered: 05/28/2020)
08/07/2020	<a href="#">73</a>	NOTICE: The Clerk of Court is in possession of the following non-electronic exhibit(s): NOTICE of submitting CD containing the Certified Record of Arizona Supreme Court Case Number CR-08-0025-AP and Maricopa County Superior Court Case Number CR2002019595, filed on October 28, 2015. Pursuant to LRCiv 79.1, notice is hereby given that the Clerk will destroy or dispose of this exhibit 30 days from the date of this Notice. If the filing party fails to retrieve the exhibit(s) within 30 days, the exhibit(s) will be destroyed. (LFIG) (Entered: 08/07/2020)
04/30/2021	<a href="#">74</a>	NOTICE of Appearance by Amanda Christine Bass on behalf of Clarence Wayne Dixon. (Bass, Amanda) (Entered: 04/30/2021)

04/30/2021	<a href="#">75</a>	STIPULATION <i>for Order Allowing Confidential In-Person Visit</i> by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Text of Proposed Order)(Bass, Amanda) (Entered: 04/30/2021)
04/30/2021	<a href="#">76</a>	NOTICE of Attorney Substitution by Lacey Stover Gard. (Gard, Lacey) (Entered: 04/30/2021)
04/30/2021	<a href="#">77</a>	ORDER granting the parties' <a href="#">75</a> Stipulation or Order Allowing Confidential In-Person Visit. ORDERED that Dr. Bhushan Agharkar be permitted to have a confidential in-person visit with Mr. Dixon for psychiatric evaluation under the terms set forth in this Order. IT IS FURTHER ORDERED that the Clerk of Court forward a copy of this Order to counsel of record; to ADCRR through its Inmate Legal Access Monitor, Loresa Purden, to Michael Gottfried, Assistant Attorney General, and to Jeffrey Sparks, Assistant Attorney General. Signed by Judge Diane J Humetewa on 4/30/2021. (See Order for details.) (LFIG) (Entered: 04/30/2021)
07/01/2021	<a href="#">78</a>	NOTICE of Attorney Withdrawal of <i>Myles A. Braccio</i> filed by Lacey Stover Gard. (Gard, Lacey) (Entered: 07/01/2021)
02/07/2022	<a href="#">79</a>	STIPULATION <i>for Order Allowing Visit for Blood Draw of Petitioner</i> by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Proposed Order Proposed Order)(Bass, Amanda) (Entered: 02/07/2022)
02/15/2022	<a href="#">80</a>	ORDER: IT IS ORDERED that the Stipulation for Order Allowing Blood Draw of Petitioner (Doc. <a href="#">79</a> ) is GRANTED. IT IS FURTHER ORDERED that Kaila Ford be permitted to have a confidential, in-person medical visit with Mr. Dixon for purposes of drawing his blood subject to the above agreed-upon terms. (See Order for full details.) Signed by Judge Diane J Humetewa on 2/15/22. (SST) (Entered: 02/15/2022)
04/14/2022	<a href="#">81</a>	STIPULATION <i>for Order Allowing Medical Examination and Blood Draw</i> by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Proposed Order)(Bass, Amanda) (Entered: 04/14/2022)
04/14/2022	<a href="#">82</a>	ORDER granting the <a href="#">81</a> Stipulation. ORDERED that Ira Ehrlich and Rudy Benavidez be permitted to have a confidential, in-person medical visit with Mr. Dixon for purposes of conducting a medical evaluation and drawing his blood subject to the above agreed-upon terms. IT IS FURTHER ORDERED that the Clerk of Court forward a copy of this Order to counsel of record; to ADCRR through its Inmate Legal Access Monitor, Loresa Purden; to Ashley Zuerlein Assistant Attorney General; and to Jeffrey Sparks, Assistant Attorney General. Signed by Judge Diane J Humetewa on 4/14/2022. (See Order for details.) (LFIG) (Entered: 04/14/2022)
04/25/2022	<a href="#">83</a>	STIPULATION <i>for Order Allowing Sputum Sample Collection</i> by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Proposed Order Proposed Order)(Bass, Amanda) (Entered: 04/25/2022)
04/25/2022	<a href="#">84</a>	ORDER granting the Stipulation for Order Allowing Sputum Sample Collection (Doc. <a href="#">8</a> ). ORDERED that Rudy Benavidez be permitted to have a confidential, in-person medical visit with Mr. Dixon for purposes of conducting a sputum sample collection subject to the above agreed-upon terms. ORDERED that the Clerk of Court forward a copy of this Order to counsel of record; to ADCRR through its Inmate Legal Access Monitor, Loresa Purden; to Ashley Zuerlein Assistant Attorney General; and to Jeffrey Sparks, Assistant Attorney General. Signed by Judge Diane J Humetewa on 4/25/2022. (See Order for details.) (LFIG) (Entered: 04/25/2022)
05/09/2022	<a href="#">85</a>	NOTICE OF ATTORNEY APPEARANCE: Eric Zuckerman appearing for Clarence Wayne Dixon. . (Bass, Amanda) (Entered: 05/09/2022)
05/09/2022	<a href="#">86</a>	APPLICATION for Writ of Habeas Corpus 28 U.S.C. 2254 by Clarence Wayne Dixon. (Bass, Amanda) (Entered: 05/09/2022)

05/09/2022	<a href="#">87</a>	MOTION to Stay <i>Execution</i> by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Proposed Order Proposed Order)(Bass, Amanda) (Entered: 05/09/2022)
05/09/2022	<a href="#">88</a>	ORDER that Respondents shall file a response to the Petition for Writ of Habeas Corpus (Doc. <a href="#">86</a> ) and Motion to Stay Execution (Doc. <a href="#">87</a> ) no later than <b>6:00 p.m. on Monday, May 9, 2022</b> . Due to the expedited nature of the request, the Court will not permit a reply. Signed by Judge Diane J Humetewa on 5/9/2022. (LFIG) (Entered: 05/09/2022)
05/09/2022	<a href="#">89</a>	NOTICE re: filing the state court record by Clarence Wayne Dixon . (Attachments: # <a href="#">1</a> Attachment Special Action Vol 1, # <a href="#">2</a> Attachment Special Action Vol 2-3, # <a href="#">3</a> Attachment ROA1-24, # <a href="#">4</a> Attachment ROA 24-29, # <a href="#">5</a> Attachment ROA 30-40, # <a href="#">6</a> Attachment ROA 41-45, # <a href="#">7</a> Attachment Pinal Exh 1-22, # <a href="#">8</a> Attachment Pinal Exh 23-39, # <a href="#">9</a> Attachment Pinal Transcripts)(Bass, Amanda) (Entered: 05/09/2022)
05/09/2022	<a href="#">90</a>	MOTION for leave to file non-electronic exhibit by Clarence Wayne Dixon. (Attachments: # <a href="#">1</a> Proposed Order Proposed Order)(Bass, Amanda) (Entered: 05/09/2022)
05/09/2022	<a href="#">91</a>	ORDER granting the <a href="#">90</a> Motion for Leave to File Non-Electronic Exhibit (Doc. <a href="#">90</a> ). IT IS FURTHER ORDERED the CD-ROM containing the audio recording of the competency hearing held in <i>In re State of Arizona v. Clarence Wayne Dixon</i> , No. SI11100CR200200692 (Pinal Cnty. Super. Ct.) shall be filed directly at the Clerk's Office no later than 2:00 p.m. today. Signed by Judge Diane J Humetewa on 5/9/2022. (LFIG) (Entered: 05/09/2022)
05/09/2022	<a href="#">92</a>	NOTICE re: of Filing Non-Electronic Exhibit by Clarence Wayne Dixon re: <a href="#">91</a> Order on Motion for Miscellaneous Relief, . (Bass, Amanda) (Entered: 05/09/2022)
05/09/2022		Remark: One Flash Drive - as outlined in the Petitioner Clarence Wayne Dixons re: Notice of Filing Non-electronic Exhibit (Doc. <a href="#">92</a> ) has been received, and will be stored in the Phoenix file room. This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (HLA) (Entered: 05/09/2022)
05/09/2022	<a href="#">93</a>	NOTICE of Appearance by Jim D Nielsen on behalf of David Shinn. (Nielsen, Jim) (Entered: 05/09/2022)
05/09/2022	<a href="#">94</a>	RESPONSE to Motion re: <a href="#">87</a> MOTION to Stay <i>Execution</i> [ <i>RESPONSE TO MOTION TO STAY EXECUTION AND ANSWER TO PETITION FOR WRIT OF HABEAS CORPUS</i> ] filed by David Shinn. (Attachments: # <a href="#">1</a> Exhibit A)(Nielsen, Jim) (Entered: 05/09/2022)
05/09/2022	<a href="#">95</a>	RESPONSE in Opposition re: <a href="#">87</a> MOTION to Stay <i>Execution Crime Victim's Objection to Inmate Dixon's Motion for Stay of Execution</i> filed by Leslie James. (Clase, Colleen) (Entered: 05/09/2022)
05/10/2022	<a href="#">96</a>	ORDER denying the Petition for Writ of Habeas Corpus (Doc. <a href="#">86</a> ) and denying as moot, the Motion for Stay of Execution. (Doc. <a href="#">87</a> ). IT IS FURTHER ORDERED denying a certificate of appealability. Signed by Judge Diane J Humetewa on 5/10/2022. (See Order for details.) (LFIG) (Entered: 05/10/2022)
05/10/2022	<a href="#">97</a>	CLERK'S JUDGMENT - IT IS ORDERED AND ADJUDGED that pursuant to the Court's Order filed May 10, 2022, Petitioners Petition for Writ of Habeas Corpus pursuant to 28 U. S. C. § 2254 is denied. Petitioner to take nothing and this action is hereby dismissed. (LFIG) (Entered: 05/10/2022)
05/10/2022	<a href="#">98</a>	NOTICE OF APPEAL to 9th Circuit Court of Appeals re: <a href="#">96</a> Order on Motion to Stay, <a href="#">97</a> Clerks Judgment, by Clarence Wayne Dixon. (Bass, Amanda) (Entered: 05/10/2022)